Essential Services for Health In Ethiopia
Mid-Term Evaluation

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EXECUTIVE SUMMARY

In November and December 2006, a team of 10 experts evaluated the Essential Services for Health in Ethiopia (ESHE) II Project, implemented locally by John Snow Incorporated (JSI) in association with Abt Associates, the Academy for Education Development, and Initiative, Inc. The evaluation focused on child health and health reform and systems strengthening viewed in the context of the project's strategic framework: (1) Strengthen Health Worker Skills; (2) Improve Health Systems; and (3) Improve Community Household Practices.

The evaluation findings indicate that the project is on track to meet its LOP goals, objectives and targets of improving child health in 64 woredas located in the focus regions of Amhara, Oromia, and SNNP. ESHE has achieved notable improvements in immunization coverage, vitamin A use and breastfeeding behaviors in the project areas (see Section D.3.) The project has forged strong links between its network of volunteer community health promoters and the expanding FMoH network of Health Extension Workers, thereby improving referrals and supervision. Its behavior change communication materials including the Immunization Diploma and Family Health Card are valued by health workers and community members alike, and have been adopted and replicated in non-ESHE zones by other organizations.

A number of systems improvements introduced under ESHE complement and multiply the impact of efforts to improve health worker skills and community outreach. Improvements to the Health Management Information System, and the introduction of supportive supervision, standards of performance and periodic performance review meetings have improved the quality and targeting of services. ESHE contributions to National Health Accounts, Special Pharmacy guidelines, and to the development and implementation of the legal framework for the health care financing strategy at the national and regional levels has led to increased allocations to the health sector and laid the foundation for user fee retention and the rational use of these revenues.

To achieve program objectives, ESHE has developed and implemented a broad range of training programs focused on improving health worker technical and management skills. Additional training programs were added following a contract amendment in 2005, reflecting expanded training for HEWs to strengthen the link between ESHE community health promoters and the priority FMoH Health Services Extension Program (HSEP). The majority of training programs are on track to meet or exceed project targets (see Annex G).

The GOE Health Sector Development Plan III (HSDP III) and the HSEP serve as the framework for activities implemented under ESHE. ESHE participated in the design and costing of HSDP III and has adapted its approach and programs to closely align with national health sector policy. ESHE was also an active member of the Child Survival Partnership which provided technical input for development of the Ethiopia National Child Survival Strategy in 2005.

ESHE has contributed to implementation of HSDP III priorities through technical assistance at all levels of health services delivery, most importantly, community-based services and programs. In each of its three focus regions, ESHE has organized strategic planning workshops involving regional health bureau, zonal, and woreda staff, and NGO partners to ensure alignment of its work plans and activities with the regional HSDP strategy.

ESHE also supports GOE priorities under its health care financing component. The Health Care Financing strategy was developed by the FMOH and ratified by the Council of Ministers in 1998. ESHE is working to realize a number of the strategy components including development of National Health Accounts; introduction of the Marginal Budgeting for Bottlenecks (MBB) tool; and development of a district-level costing tool; and development and application of the legal framework for health care reforms, including revenue retention, fee revision, decentralization of health facility management, outsourcing of non-clinical activities, improvements to waiver and exemption systems, and initiating health insurance schemes.

The evaluation team believes that the project's strategic approach, namely the Three Pillars strategy, including community mobilization, is both appropriate and effective. In Ethiopia, there is recognition that improvements in facility-based services alone cannot contribute significantly to reductions in child mortality. Access to qualified health providers or facilities is limited and many children die at home owing to lack of knowledge or delays in seeking appropriate care. ESHE has worked effectively to simultaneously strengthen health systems, health worker skills and positive community and household health practices. The evaluation team believes that the Three Pillar approach multiplies community-level impact and that the large gains in use of health products and services are largely attributable to this approach.

The evaluators also believe that in the Ethiopian context, a community-level program will be a necessary element of any effort to improve access to quality child health services. The broader question of whether the CHPI is the most feasible and practical community mobilization model for Ethiopia will require further study (see Major Recommendation 7.)

ESHE has achieved its results through transparent, peer-based working relationships with FMoH staff and other partners. The evaluation team gathered an extensive amount of information on the topic of coordination and relationships with partners from observation, context and interviews. The majority of working relationships were positive, productive, collegial and valued, and many examples are cited in the narrative sections of this report.

ESHE is on schedule in achieving its objectives despite some universal constraints that have implications for implementation and sustainability alike. High staff turnover at all health system levels has often required orientation and additional rounds of training for new staff. Counterparts at all levels face competing priorities, resulting in divided attention and difficulty realizing planned activities. Shortages of equipment, spare parts for refrigerators in some woredas, and IMCI drugs pose a challenge to full-scale implementation. Delays in ratifying health care financing reform regulations and directives by regional cabinets and RHBs resulted in implementation delays. These constraints should be taken into consideration in future designs.

This evaluation report contains two categories of guidance and recommendation. Suggestions for fine-tuning ESHE implementation over the remaining two years of the project are captured as the **Implementation Guidance**, which is fully discussed in the narrative and summarized in Annex H. **Major Recommendations**, which are strategic in nature are fully discussed in the narrative and summarized on the following pages. **Recommendations for Future USAID sector support** are laid out and summarized in a separate memorandum.

SUMMARY OF MAJOR RECOMMENDATIONS

Child Survival Interventions and Health Worker Skills

Recommendation 1: Strengthen monitoring and reporting on program effectiveness and feasibility, especially for newly introduced program areas including Integrated Management of Newborn and Childhood Illness (IMNCI), community based pneumonia treatment, newborn care, and the Community Therapeutic Care/Community Nutrition Program.

Recommendation 2: Promote and facilitate the adoption of "best practices" identified in the course of ESHE implementation as FMoH standards, for example, linking Health Extension Workers trained in IMNCI to community health promoters activities.

Recommendation 3: Mobilize and leverage partner resources to support heavy start up costs for training and follow-on support of programs like IMNCI, Essential Nutrition Actions and EPI, using this as an opportunity to forge a partnership for scaling up these strategies in ESHE focus regions.

Recommendation 4: Explore and strengthen links between ESHE and programs serving as entry points for care of HIV-infected children.

Recommendation 5: Strengthen referral links between communities and facilities to support adequate follow up in the community and ensure that children at the highest risk of dying are not lost to follow up.

Recommendation 6: The private/informal sector is a key source of care for children. Develop strategies to engage private/informal providers (i.e. drug sellers, traditional healers) as partners in the broader system of care for children.

Community Health Promotion

Recommendation 7: Initiate a dialogue with the GOE and other organizations financing community-based volunteers with the objective of harmonizing approaches where possible; to inform that process, appraise the cost-effectiveness, feasibility and impact of models in use.

Health Systems Strengthening

Recommendation 8: Focus on developing capacity within the GOE for National Health Accounts, policy studies, and implementation of the legal framework, working with the GOE to develop an explicit and realistic timeline along with progress benchmarks to transfer these capacities. Identify core groups within the GOE where capacity transfer could be most successful and explore cost-sharing arrangements with the GOE to foster greater institutionalization of activities.

Recommendation 9: Focus on implementation of legal framework, specifically, helping the regions implement the directives using a capacity-transfer approach. Many of the components of the legal framework are complex in nature and will require significant training at all decentralized levels. Given limited resources, EHSE should develop a strategic approach to TOT and end-user training support that leverages other sources of finance, such as GOE cost-share.

Recommendation 10: Ensure optimal use and oversight of retained revenue, a significant resource that can be used to improve the availability and quality of child health care. ESHE should devote the majority of its health care financing resources to this critical area over the coming two years.

Recommendation 11: Develop a strategic and deliberate approach for disseminating health finance and systems results to non-ESHE woredas; explore cost-share arrangements with GOE and leverage other partners to ensure that cross-cutting systems activities are successful in non-ESHE areas.

Recommendation 12: Support building blocks of social health insurance, including: a) Quality of care supervision; b)Optimal use and oversight of retained revenues; c) Citizen input into quality improvements; d) Ability to target the poor; and e) User fee revision to reflect marginal cost of services and willingness-to-pay.

ACRONYMS AND ABBREVIATIONS

BCC	Behavior Change Communication
BOFED	Bureau of Finance and Economic Development
CBRHA	Community Based Reproductive Health Agent
CHP	community health promoter
CHW	community health worker
CHPI	Community Health Promotion Initiative
C-IMCI	Community-Integrated Management of Childhood Illness
CNP	community nutrition promoter
CRP	community resource person
CTC	community therapeutic care
DHS	Demographic and Health Survey
DPT	diphtheria, pertussis, tetanus
ENA	essential nutrition actions
EPI	Expanded Program on Immunization
ESHE	Essential Services for Health in Ethiopia
FHC	Family Health Card
FMoH	Federal Ministry of Health
GOE	Government of Ethiopia
HCF	Health Care Financing
HCP	Health Communications Partnership
HEW	health extension worker
HH	household
HMIS	Health Management Information System
HSDAMP	Health Service Delivery, Administration and Management Proclamation
HSEP	Health Services Extension Program
IEC	Information, Education and Communication
ID	Immunization Diploma
IMCI	integrated management of childhood illness
IMNCI	integrated management of newborn and childhood illness
IRT	Integrated refresher training
M&E	monitoring and evaluation
MGD-4	Millennium Development Goal-4
NDA	no data available
MOFED	Ministry of Finance and Economic Development
NGO	non-governmental organization
NHA	National Health Accounts
OPV	oral polio vaccine
ORS	oral rehydration solution
PASS	Pharmaceutical Administration and Supply Services
PMI	Performance Management and Improvement
RHB	Regional Health Bureau
SNPP	Southern Nations, Nationalities and Peoples
TBA	Traditional Birth Attendant

TFU	Therapeutic Feeding Unit
TOT	training of trainers
TT	tetanus toxoid
TVETI	Technical Vocational Education and Training Institutes
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WorHO	woreda health office
ZHD	zone health desk

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The United States Government-appointed members of the evaluation team greatly appreciate the contributions of the GOE members of the team. Their insights, extensive experience and hands-on knowledge of the policy and implementation environments contributed immensely to the evaluation and this report.

The team would also like to thank the USAID HAPN team, particularly Susan Anthony, Judith McCord and Eshete Yilma for their insights and observations, as well as their willingness to provide additional guidance and background as needed. Team members are particularly appreciative of its interactions and discussions with CTO Eshete Yilma, many of which took place well into evening and weekend hours, owing to work schedules.

Finally, we are extremely grateful to Brenda Moreno, local coordinating consultant, who not only undertook all the logistics support and coordination for the evaluation team advance planning and field visits, but who participated as a team member during site visits and the formulation of report recommendations.

The Evaluation Team

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I. BACKGROUND

With a very low resource base and rapidly growing population, Ethiopia is one of the poorest countries in the world. Its per capita gross national income of US$ 100 in 2002 compares poorly with the average of $US 450 for Sub-Saharan Africa (World Bank, 2006). It is the second most populous country in sub-Saharan Africa, with its current population of 76 million growing by an average of two million annually. Approximately 85% of the population resides in rural areas and the population is young, with 48% under the age of 15. Among the nine regional states, Amhara, Oromiya and Southern Nations, Nationalities and Peoples (SNNP) comprise about 80 per cent of the total population of the country.

Even in a non-drought year, approximately 472,000 Ethiopian children die each year before their fifth birthday, mainly from preventable causes. About 90% of mortality in under-fives is caused by pneumonia, neonatal complications, malaria, dehydration associated with diarrhea, and measles. Malnutrition is a direct or indirect cause in 58% of these deaths (Federal Ministry of Health Child Survival Strategy, 2004). 72% of these deaths are preventable through access to and use of basic primary health care services.

Levels of malnutrition in children and women are extremely high. Almost half (47%) of children under five are stunted and more than one in four women (27%) are at critically low body mass index, resulting in low birth weight infants who, in turn, are at higher risk of mortality and find their health compromised throughout their lives. Malnutrition is a chronic phenomenon and when an emergency hits, the survival of vulnerable population groups is at great peril.

Only about 50% of the Ethiopian population has access to health services and those services often lack adequate and trained personnel, equipment and essential drugs. Total per capita health expenditure from all sources including government is low at $7.14 versus an average of $12 per person in the Africa region and the $34 per capita WHO estimates is needed to provide the minimum package of essential health services.

The Government of Ethiopia health development strategy is laid out in the Health Sector Development Program (HSDP), currently in its third five-year cycle, HSDP III. The focus of HSDP III is on primary health care and preventive services, with a focus on extending outreach services to reach villages and households and achieve universal primary health care coverage by the year 2008. The strategy aims to reduce under-five mortality from 140 to 85 per 1000 population and the infant mortality rate from 97 to 45 per 1000 population during this same period. A critical element of the HSDP is the Health Services Extension Program (HSEP), which plans to deploy 30,000 health extension workers at the rural health post level by 2008.

USAID works within the framework of the HSDP III to address health sector challenges in Ethiopia. USAID Strategic Objective 14, “Use of High Impact Health, Family Planning and Nutrition Services, Products and Practices Increased,” promotes the availability and use of child survival services at the community level and systemic health systems reform.

The Essential Services for Health in Ethiopia (ESHE) II project is USAID's flagship child health and health systems strengthening technical assistance program in Ethiopia. Beginning in November, 2003 and building on ESHE I project experience in SNNP, USAID has expanded support to Oromia and Amhara. In these three target regions, ESHE supports child health activities in 64 selected woredas serving 15 million. In the Health Sector Reform area, the project works with the Ministry of Finance and Economic Development (MOFED) and the Federal Ministry of Health (FMoH), Regional Health Bureaus, Regional Health and Economic Development Bureaus, and woreda health offices to institute and implement health sector financing reforms designed to improve financial resources to the sector.

Major program components of ESHE include: delivery of priority child health interventions (immunization, essential nutrition actions and Integrated Management of Newborn and Childhood Illness), behavior change communication (BCC), the Community Health Promotion Initiative (CHPI), health systems performance improvements (performance standards, supportive supervision, and health management information systems) and support for the development and implementation of health care financing reforms. At the community level, ESHE has forged a direct link between the community-based health promoters trained under CHPI and the health extension workers (HEWs) based at health posts working under the auspices of the HESP.

CHILD HEALTH SITUATION

As indicated in the 2005 EDHS, Ethiopia is experiencing substantial declines in childhood mortality, although levels remain unacceptably high and there are wide differences by region as well as by wealth quintile. Neonatal mortality has declined from 49 deaths per 1000 (2000 EDHS) to 39 per 1000; infant mortality, from 97 to 77 per 1,000; under-five mortality from 166 to 123 per 1000. Yet, infant mortality rates are 20% higher and under-five mortality rates 38% higher among children from the poorest quintile (compared to children from the richest quintile). The USAID focus areas include the 3 largest regions which are among those experiencing the highest mortality rates*:

Mortality rates by USAID focus region

Region	NMR	IMR	<5MR
Amhara	50	94	154
Oromiya	40	76	122
SNNP	36	85	142

* *mortality rates for the 10 yr period preceding the survey (2005 EDHS)*

About 90% of under-five mortality is due to pneumonia, malaria, diarrhea, neonatal causes and measles, with malnutrition and HIV/AIDS as underlying causes in 57% and 11% of deaths, respectively.[1] Prompt diagnosis and appropriate treatment can prevent large numbers of deaths, yet few children receive appropriate care. From the 2005 EDHS, 19% of children under five with symptoms of ARI were taken to a health facility or provider, and of these, only 5% received antibiotics. Only 3% of under-fives with fever/malaria received an anti-malarial drug. And 37% of children with diarrhea were treated with some form of ORT (i.e. ORS or recommended home fluids, and increased fluids) with less than half of mothers (46%) knowledgeable about ORS.

[1] National Strategy for Child Survival in Ethiopia, 2005

Malnutrition remains a serious problem and is closely linked to inappropriate feeding practices and food insecurity in many parts of the country: 47% of under-fives were classified as stunted, 11% wasted and 38% underweight. Sixty-seven percent of infants less than 2 months of age were exclusively breastfed, and by 4-5 months only 32% were still exclusively breastfed. Data show delays in the introduction of complementary foods at 6 months, with complementary feeding for children between 6-8 months of age at 50%.

Other interventions also show poor coverage: 46% of children 6-59 months received vitamin A; only 6% of households owned a bednet; TT2 was 28% and DPT3 coverage was 32% (2006 UNICEF-WHO estimate for DPT3 is 66%) with wide regional variation. EDHS 2005 data across the USAID focus regions shows high unmet need for these and other interventions that have been prioritized under the National Strategy for Child Survival in Ethiopia (2005):

Selected coverage indicators by USAID focus region

Region	DPT3 (EDHS) / DPT3 * (WHO/UNICEF)	TT2	Exclusive BF**	Diarrhea treated with ORT	ARI taken to HF or provider	Fever treated with Antimal.	HHs owning a bednet	Vit A supp.
Amhara	32 / 68	25	74	33	15	2.4	4	43
Oromiya	29 / 58	28	39	40	20	1.5	3	43
SNNP	33 / 81	33	58	31	20	6.3	8	50

** 2006 EPI Coverage Survey*
***ESHE 2004 baseline survey; EDHS data unavailable*

II. PURPOSE

The purpose of this activity was to conduct an evaluation of the Essential Health Services for Health in Ethiopia (ESHE) Project, implemented through a contract with John Snow International (JSI). The evaluation, conducted by a team of international and local experts, consisted of a comprehensive technical and managerial review of the appropriateness of the approach and results to date. The objectives of the evaluation are:

- To assess the contributions JSI/ESHE has made to child health and health systems improvement in the focus woredas, regions and at the national level.
- To assess ESHE cornerstone strengths and innovative activities and determine those that should be continued and emphasized in follow-on activities.
- To evaluate ESHE's approach in the context of the Host Government's Health Services Extension Program and Health Sector Development Program priorities.
- To assess ESHE's collaborative and coordination efforts with USAID partners, host government and other stakeholders.
- To present recommendations for future ESHE programming.
- To present recommendations for future USAID support for maternal, newborn and child health programming and health sector reform/finance.

Two major program areas were evaluated: (a) Child Health (b) Health Sector Reform and System Strengthening. These program areas were reviewed in the context of the project's

strategic framework: (1) Strengthen Health Workers Skills; (2) Improve Health Systems; and (3) Improve Community Household Practices.

III. METHODOLOGY

A team of ten persons conducted this mid-term evaluation of the ESHE project in November and December 2006. Members of the team included five senior Government of Ethiopia (GOE) experts from Regional Health Bureaus (RHBs) and the Ministry of Finance and Economic Development (MOFED); a retired USAID Foreign Service Officer with extensive health sector and Africa Bureau experience who served as consultant team leader; one USAID/Washington senior technical advisor in child survival (CS); one USAID/Washington health systems advisor; one USAID/Washington Performance Management and Improvement (PMI) advisor; and a local coordinating consultant.

Prior to arriving in Ethiopia, team members reviewed project documents provided by USAID/Ethiopia and by JSI headquarters. Team members attended an ESHE project briefing and presentation at JSI, with the team leader participating by teleconference. The team leader reviewed relevant interview instruments and prepared draft guidance to prompt questions for interviewing various stakeholders as well as a data-recording tool for these interviews; and developed and forwarded a list of priority issues and questions to serve as the framework for initial briefings with JSI/Ethiopia staff on November 29. The team leader also worked with the local coordinating consultant to plan a two-day team orientation meeting, develop and refine the team's stakeholder interview schedule and site visit itinerary, and to identify and assemble relevant documents and resources. During the team orientation, the consultant led the team in the development of a comprehensive site visit questionnaire and data-recording tool, to guide field interviews. The questionnaire was constructed to provide qualitative and quantitative information corresponding to specific questions contained in the evaluation Scope of Work. The team leader developed a draft table of contents for the final report as a frame of reference for team members, and met with the team to assign report preparation responsibilities and provide written report preparation guidance during the initial week of the evaluation.

For the field visit stage of the evaluation, the team divided into three sub-teams that undertook five days of fieldwork in project areas including Amhara, Oromia, and Southern Nations, Nationalities and Peoples (SNNP). Although sites were initially selected to offer the broadest possible exposure to the range of project interventions, team members modified the field visit itinerary somewhat to ensure that they used their time efficiently in the field and were able to focus on the sites, institutions and observations most relevant to evaluation objectives. Each team consulted with regional, zonal, woreda and kebele officials, staff and volunteers and observed community-level activities in an effort to assess ESHE project contributions to USAID's child survival and health systems strengthening priorities (see Annex B for a list of sites visited and persons met).

All of the sub-teams used standard interview guides to ensure consistency in information-gathering and reporting of the qualitative data collected. Upon completion of fieldwork, the three sub-teams reconvened in Addis to review and discuss their findings and proposed recommendations, highlighting successes and strengths, and identifying gaps and constraints.

Finally, the entire team came to consensus on proposed actions for fine-tuning implementation during the final two years of ESHE implementation as well as program-level recommendations for shaping the direction of future USAID-funded child health services and health systems strengthening.

Following the fieldwork, the writing team prepared a first draft of the evaluation report based primarily on stakeholder interviews and site visit findings. The team met with key USAID staff to present and discuss its summary findings and planned recommendations, and incorporated the key themes of these discussions into its draft report. Following submission of the draft report, USAID provided written feedback to the team leader, who was responsible for incorporating mission feedback and guidance into the final evaluation report.

IV. FINDINGS

A. PILLAR I: STRENGTHENING HEALTH WORKER SKILLS

1. Background

The ESHE project is currently working to build health worker skills and capacity in the areas of IMCI, ENA and EPI. Consultations with the FMOH and health partners have led to the development of training courses and materials that have been utilized at Regional/ Zonal/ Woreda/ facility and community levels throughout both ESHE and non-ESHE focus areas. To sustain performance post-training, ESHE has implemented supportive supervision and H/MIS monitoring. At national level, the project has also provided valuable input to development of IEC and M&E components of the Integrated Refresher Training (IRT) for the Health Extension Program. Findings are discussed separately for each of the main technical areas below. (Capacity-building in non-technical areas and for community health promoters is addressed in subsequent sections.)

2. Discussion and Conclusions

a. Integrated Management of Newborn and Childhood Illnesses (IMNCI)

The Integrated Management of Newborn and Childhood Illnesses strategy is central to Ethiopia's Health Sector Development Programmed as it addresses the conditions responsible for 90% of childhood deaths in the country. Ethiopia pre-tested the draft version of IMCI in 1994 and since then has been implementing the 3 main components of 1) improving health worker skills, including pre-service and in-service training, 2) improving health systems including the availability of essential and pre-referral drugs, referral pathways and supervision, and 3) promoting a set of 20 key family and community practices (C-IMCI) to improve physical growth and mental development, prevent disease, and facilitate appropriate home care and care-seeking behaviors. The previous IMCI guidelines were updated in 2006 to include care and management of newborns below the age of 7 days and childhood HIV/AIDS, hence the name Integrated Management of Newborn and Childhood Illnesses, or IMNCI**.**

Previous implementation of the IMCI strategy has been slow due to budget constraints, high staff turnover, and lack of adequate supplies/equipment as well as supportive supervision. Since 2001, IMCI has reportedly been in an expansion phase but only 36% of health facilities are implementing IMCI and 4303 health workers (43% of target) have been trained.[2] From an ESHE survey, of 580 under-five outpatient consultations observed, children managed with the IMCI algorithm were only: 16% in Amhara, 0% in Oromia and 32 % in SNNP.[3] Also, ESHE data show a wide range across the project areas in terms of availability of essential oral drugs needed for IMCI: cotrimoxazole (74 – 92%), anti-malarials (55-93%), and ORS (81-92%). Implementation of the community component (C-IMCI) by non-ESHE partners has also been limited. UNICEF pilot activities begun in 2 districts in 2004 are reportedly expanding to 30 districts. NGOs are implementing activities within the C-IMCI framework in other districts. Varying approaches, materials and incentives exist for introducing some mix of the 20 C-IMCI preventive and curative key family practices, and these have yet to be consolidated and harmonized.

ESHE has played a lead role, in partnership with the MOH, WHO, UNICEF, USAID and Save the Children/USA, to incorporate important new elements into the guidelines i.e. essential newborn care, care of sick newborns and HIV/AIDS, and modify the training course to accelerate roll out. A notable departure from previous IMCI implementation has been the focus on capacity-building of HEWs to extend the reach of both preventive and selected curative services in the community. Specifically, ESHE has contributed to the development of IMNCI health worker skills training courses and supportive supervision at health center and health post levels (currently being field tested in one district in SNNPR), and is using its Community Health Promoter Initiative as a successful vehicle for introducing many of the C-IMCI key practices (see also Section B.2.a.).

At facility level, ESHE has provided IMNCI training since May 2006 to 31 health workers (HEW and health center staff) covering 8 health posts and 5 health centers in SNNPR; 13 health center staff have been trained in other Regions. Plans will reportedly be underway soon to create a pool of facilitators at various levels for IMNCI implementation and supervision across the 64 woredas. This training-of-trainers approach looks to be potentially effective in building initial localized training capacity and institutionalization, and will likely enable IMNCI to be rolled out across the Regions even in non-ESHE woredas. But, given delays in startup (i.e. acute watery diarrhea outbreaks, and a 2006 contractual amendment to allow for HEW training) and other training burdens (i.e. new woredas as a result of the re-structuring, high staff turnover), the LOP targets of 2000 HEWs and 1350 CHPs may be difficult to meet given that only 9 and 35, respectively, have been trained so far. This, in turn, may affect ESHE's ability to achieve the desired level of program scale and impact given the remaining 22 months in the project.

Of note, FMOH staff valued the technical expertise of ESHE staff and appreciated ESHE support to the National Child Survival Partnership effort and development of the National Child Survival Strategy, but also expressed some concerns about the project's 'pilot' approach, coordination with MOH plans, vertical nature of introducing the Community Health Promoter Initiative and IEC materials, and development of new reporting formats. Notwithstanding these issues, in

[2] Health Sector Strategic Plan (HSDP III), 2005

[3] Twelve different Baseline Health Surveys, conducted in: Amhara, Oromia and SNNPR, March 2005.

SNNPR, the region where IMNCI is being introduced, there is broad recognition and appreciation at all levels of ESHE's contributions to improving access and quality of needed child health services, especially at community level. Newborn sepsis in particular is thought to be a major cause of higher level referral and infant deaths in this region, and the IMNCI strategy, when effectively applied and with adequate supports at health center and health post levels (such as those being institutionalized by ESHE), promises to make significant contributions to reducing newborn as well as other childhood deaths.

Evidence of improved quality of care provided to sick children as a result of either quarterly supportive supervision or more frequent ESHE monthly follow up visits could not be systematically analyzed during this evaluation, but the inclusion of case observations in the integrated checklist tool will provide potentially useful information to re-enforce health worker skills and correct performance problems on site. From visits to select health posts and a check of reporting registers, it would seem that at 6 months post-IMNCI training, HEWs were managing sizeable numbers of sick children on the days they were stationed at the post (e.g. 10-15 cases per day; 1-2 days per week) and seemed confident in their ability to provide quality integrated care and treatment as per the IMNCI algorithm. Because some IMNCI-trained HEWs will attend births, this is seen as an excellent opportunity to promote essential newborn care i.e. ensure immediate warming and drying of the infant, clean cord care, initiation of breast feeding, and referral as needed, but when asked, HEWs gave variable responses as to when the first postpartum visit could be done (ranging from "immediately" to "within 45 days"). Referral, apart from that being undertaken as part of the Community Therapeutic Care program, (see Nutrition below), was found to be weak in several health facilities visited, and it is possible many severely ill children are being lost to follow up (mainly for ARI and malaria, with one health post reporting 17 referrals for neonatal sepsis).

At present, HEW skills training limits treatment to use of Coartem® for malaria and ORS (and Zinc when available) for diarrhea. ESHE has also been a strong advocate at National level for including community based treatment of pneumonia as a key intervention to deliver at health post level. Globally, WHO, UNICEF and USAID, have endorsed the introduction of community-based treatment including pneumonia as a way to achieve the MDG reduction in childhood mortality. With USAID global and Mission support, other African countries are already moving forward with significant community based treatment programs for pneumonia integrated with diarrhea and malaria case management where appropriate. The small but growing experience suggests that community-based activities must be effectively linked with health facilities for supervision, drugs and care of referred patients. Thus, the ESHE approach with its various supportive elements (i.e. supportive supervision and performance improvement, post-referral follow-up by community health promoters, and influence with MOH and partners to offset stock outs of cotrimoxazole due to limited Regional drug budgets) may succeed in introducing community based treatment of pneumonia as a feasible and necessary intervention at health post level.

Implementation Guidance: In advance of IMNCI scale-up, define feasible training targets, clear objectives and a few key measures of success by project's end for facility-based IMNCI, especially for the novel approach being applied at health post level. Given the enormous investment that will be required to capacitate and support health workers to provide IMNCI

(particularly given the high rates of staff turnover, and the creation of additional woredas requiring support), ESHE (together with MOH and other partners) should measure and report on the effective implementation of IMNCI that extends beyond the currently reported numbers of health workers trained and drugs/equipment available.

At present, the ESHE M&E indicator matrix annexed in the year 4 work plan shows only DPT3 and 'checking weight against a growth chart' for assessing "Quality of key health services improved." Other 'measures of success' for IMNCI could include improvements in quality of care, rational use of drugs and intervention-specific outputs specifically related to the major causes of childhood illness. Between ESHE's baseline and end line facility assessments (which do assess health worker compliance with the IMNCI algorithm), no interim measures are yet described in project documents for case management of ARI, malaria or diarrhea (e.g. provision of integrated care, cases correctly treated with antibiotics, anti-malarials, and ORT, etc.). Such data could perhaps be mined from the wealth of data currently being collected through integrated checklists and ESHE performance improvement activities.

Implementation Guidance: Strengthen referral links between the community and health care facilities. Given the progressive improvements in case management at facility level and the reach of CHPs into the community, critical links in the referral chain (that is, where referral is even possible), should be strengthened to ensure that caretakers of referred children are able to comply with the recommended referral, and that outcomes are adequately followed up in the community.

Implementation Guidance: In line with MOH plans, mobilize and leverage partner resources to support heavy start up costs for IMNCI training and support, and use this as an opportunity to induct new partners as part of a scale up strategy in ESHE Regions. NGOs have a significant presence throughout the ESHE focus regions and should be selectively harnessed for their technical and financial support to IMNCI training and follow up. Given the project's approach to working within the existing structures of the Regional, Zonal, and Woredas health offices, ESHE is uniquely positioned to assist the MOH in better coordinating the various NGO inputs and programs. In addition, Ethiopia has recently been awarded GAVI funding for Health Systems Strengthening (GAVI HSS) and plans will include a sizeable investment in capacity-building for health center staff in IMNCI. These funds should be leveraged to fill gaps in training and other supports needed for implementation.

Implementation Guidance: Monitor and report on feasibility and effectiveness of new program components i.e. community based pneumonia treatment, newborn care. With regard to community-based treatment of pneumonia, a baseline and plan are needed to systematically monitor adequate case management by HEWs and track increased numbers of cases seen (which reflects improved demand and care seeking for ARI by the community), among other measures. Such 'hard evidence' will be needed to influence MOH policymakers to modify the current policy which restricts the types of curative services HEWs can provide in the community to treatment of malaria and diarrhea. In addition, the introduction of newborn care into IMNCI requires some special monitoring, particularly regarding the feasibility and effectiveness of HEWs (some though not all of whom are trained to attend births) in providing timely postpartum visits, essential newborn care, and treatment/referral during the first week of life.

Implementation Guidance: If feasible within the fever case management component of IMNCI, strengthen rational use of rapid diagnostic tests (RDTs) and artemesenin-based combination therapy (ACTs) in the treatment of malaria at health post level. As expressed by UNICEF and others, overtreatment of malaria is a major concern, particularly given that Coartem® is an expensive drug with a very short shelf-life, RDTs are not available everywhere (as seen during site visits), and both are being rapidly introduced throughout Ethiopia.

b. Essential Nutrition Actions (ENA)

Malnutrition remains a serious problem in Ethiopia, yet there is limited awareness in the Regions of the FMoH National Nutrition Strategy and its components. General lack of trained staff is cited as a major obstacle to implementing the nutrition strategy which needs to be better addressed in the education and curricula of health professionals.[4]

One of the key approaches for addressing malnutrition in Ethiopia is the Essential Nutrition Actions (ENA). It promotes key nutritional behaviors that are 'do-able' and scientifically proven to improve the nutrition of mothers and children. The approach focuses on 7 action areas (BF, CF, feeding of sick children, women's nutrition, vitamin A, anemia and iodine) implemented through 6 life cycle contact points (pregnancy, delivery, postnatal and FP, immunization, well child/growth monitoring, and sick child consultations). ENA is incorporated in the National Child Survival Strategy and was specifically recommended for accelerated expansion in the final evaluation of HSDP II.

To date, ESHE has been undertaking ENA trainings in collaboration with the previous LINKAGES project and is also working on a) advocacy for ENA at policy level and at Regional level, b) capacity development for health workers at regional, district, health center and health post levels, and most significantly, c) community based actions through specialized training of community nutrition promoters as well as community health promoters in some woredas. Project year 3 was a productive training year: some 1450 health workers across the 3 Regions have been trained in ENA courses --- nearly double the 735 target for the year. Overall, 393 HEWs and 1589 CHPs have been trained relative to the LOP targets of 2000 and 2180, respectively.

By all accounts and through limited visits to woredas with community nutrition promoters, the ENA training and support from ESHE is highly valued and the ENA components appear mainstreamed within various contact points such as EPI and sick child visits. From the midline community assessment in 2006, ESHE is reporting that breastfeeding practices were improving across ESHE woredas, especially with regard to giving of colostrum and appropriate frequency of breastfeeds. For Vitamin A supplementation, ESHE has exceeded its 3 year targets by a significant amount across all regions. Regarding other ENA components or contact points, it is unclear if all or only a subset will remain a focus for ESHE support in the coming years.

With OFDA funding, ESHE has been piloting an approach in Bolosso Sore woreda (one of the woredas most affected by the 2005 drought and famine emergency, and chronically food insecure) to complement the work of International Medical Corps (IMC) in implementing the Community-based Therapeutic Care (CTC) approach targeting severely malnourished children.

[4] HSDP II Final Evaluation Report, May 2006

Where previously severe and acutely malnourished children tended to be institutionalized for extended periods at hospital- and health center-based Therapeutic Feeding Units (TFUs), CTC aims to strengthen case management of malnourished children in the community, while also strengthening nutritional rehabilitation especially of acutely malnourished children and expanding use of Plumpy'nut[5] in therapeutic feeding. ESHE support focuses on the management of mildly and moderately malnourished children to prevent them from becoming severely malnourished. As such, the project is focusing on strengthening capacity of health workers, Community Health Promoters (CHPs) and specialized Community Nutrition Promoters (CNPs) to promote essential nutrition actions and counseling on improved feeding practices, facilitate appropriate referral to CTC programs, provide follow-up at home to prevent relapse, and refer to other services as needed (i.e. immunization, sick child care etc.). The World Bank food security program has used ESHE guidelines and some 104 Disaster Prevention and Development (DPPC) volunteers have also been trained.

The Head of the Woreda Health Office sees ESHE's support as important for mainstreaming CTC in the health system but also for strengthening the preventive aspects of nutrition in the community. Because of this, he endorses the CTC and CNP approach as an important way to fight the 'dependency syndrome' in communities accustomed to receiving handouts and other kinds of support during emergencies. IMC is phasing out of Bolosso Sore in 1-2 months and ESHE is planning to absorb this work at 6 outpatient therapeutic program sites. But, it remains unclear if activities can or will expand beyond a single district.

Implementation Guidance: Catalyze and monitor implementation of 'best practices' to achieve broader ENA program scale and impact. Other Regions and partners can learn from the work currently being done by ESHE to rapidly and effectively roll out various components of the ENA approach at health facility and community levels.

Implementation Guidance: Adopt successful program elements of the CTC-CNP work as a standard approach for use in emergency/post-emergency settings. In other countries, the CTC program is achieving results such as reduced child deaths due to malnutrition; fewer admissions to rehabilitation centers (relegated to only severe malnutrition or moderate malnutrition with complications); increased numbers of children being managed at community by families; empowered community leaders taking initiative in case finding and bringing children to facilities, etc. ESHE should consider adopting similar performance measures to report progress as well as facilitate uptake by MOH and partners in other districts.

c. Immunization

From the recent EPI National Coverage Survey (WHO/UNICEF 2006), national DPT3 coverage is at 66% (compared to 32% as per 2005 EDHS), but owing to disparities in access and utilization of health services it was less than 10% in some regions. Of greatest concern are the

[5] a Ready to Use Therapeutic Food (RUTF) for use in famine relief; high protein and high energy peanut-based paste packaged for distribution to children at home rather than in specialist feeding stations

high numbers of unvaccinated children --- some 800,000 children without DPT3. From the HSDP III plan, the EPI program reportedly suffers from high vaccine wastage rates (65% for BCG, 30% for measles, 20% for DPT, 15% for OPV) that are mainly due to poor planning of static and outreach sessions, lack of awareness of communities, poor management of cold chain system and the currently applied One Vial One Child Policy. In addition, the adjournment of GAVI support for injection materials (2002-2004) necessitates the financing of these commodities from the government budget and other donors. Under the EPI-Financial Sustainability Plan (November 2004), government has already taken steps to reallocate resources away from urban hospital-based curative services towards more basic primary health care services, including immunization, for the rural population. New vaccines (DTP-HepB+Hib3) are to be introduced in Ethiopia soon, with the first batch expected to arrive December 18, 2006.

Under the HSDP, the Health Extension Program is critical to achieving sustained increases in immunization coverage. HEWs are expected to register births, sensitize parents, offer regular immunization sessions that are convenient to the household, and follow up defaulters in their homes. When GAVI HSS funds are made available, the MOH and partners plan to use some of these funds to provide Integrated Refresher Training as a way to strengthen the knowledge and practical skills of HEWs (including those related to vaccine and cold chain management) and to expand and equip health posts.

At the central level, ESHE staff has been lauded for their collaboration and high quality technical support to the national EPI program. USAID/ESHE has worked well with WHO and UNICEF together as the lead technical agencies for EPI. This year, ESHE chaired the core group responsible for the 2006 EPI National Coverage Survey, provided critical inputs to GAVI HSS proposal development, and participated in orientations to conduct the immunization Data Quality Audit.

ESHE and WHO/UNICEF partners have conducted joint EPI planning, training and supportive supervision to build capacity at Regional/Zonal/ Woreda levels and ensure consistency across ESHE and non-ESHE woredas. They jointly developed a 3-day EPI refresher training package and provided decentralized training across the 3 Regions. Given the introduction of new vaccines and expected high turnover of staff, ESHE and partners will update the current materials and assist in orienting health workers, including EPI focal persons at Woreda Health Offices and health facilities. In year 3, ESHE achieved 83% of its EPI training target and exceeded its DPT3 and Polio3 coverage targets of 80% (from routine data) in all regions except Amhara (polio data missing). The project has already met its LOP target for HW training in EPI, but is at 27% of its LOP target of 2000 HEWs. Monitoring vaccine availability for all Regions shows considerable improvement since baseline: vaccine availability is near or over 90%, except polio vaccine in Oromia (87%).

From field visits and discussions with health officials at various levels, the ESHE support to immunization has been well appreciated. ESHE inputs have resulted in increased coverage and access across the project areas, especially for full immunization coverage and neonatal tetanus, and in previously poor performing districts. The work of HEWs and CHPs has helped to improve defaulter tracking and thus reduce drop-out rates (although this varies across woredas and regions. Due to strengthened supervision and monitoring, quality of immunization services has improved as demonstrated by increased use of the child vaccination card. Immunization

Diplomas given to children completing the full series of vaccinations by 1 year of age are widely used and are being taken up by WHO and UNICEF for distribution around the country.

An ongoing issue is with the quality and use of data generated by the HEWs. In some health posts visited, annual DTP3 coverage exceeds 100% due to problems with using 1994 census data to estimate the denominator (as well as some double counting during campaigns and inclusion of families from outside the catchment areas). These figures are used for reporting and, presumably, for planning and resource allocation, even when the true catchment population is known. The problem is universal but at the present time WHO is reportedly encouraging districts to use actual data in their reporting since it is understood that HEWs are registering births and know the population in their kebeles.

Implementation Guidance: ESHE should encourage Woreda Health Offices, Health Centers and HEWs to report the more accurate measures of EPI coverage, particularly if the true population is known.

Implementation Guidance: Define the 'unmet need' for child health services, such as unvaccinated children, and explore ways of reaching those within the worst performing ESHE Zones/Woredas. The main priority of the EPI program in Ethiopia is to reach the vast numbers of children who have not been vaccinated. This orientation requires that resources be specifically programmed to reach the poorest performing Regions, but also that resources be prioritized even within better performing Regions or Zones since pockets of unmet need may still exist. To assist in this effort, NGOs (some of whom are working in very remote areas) should be engaged as part of a broader plan to standardize immunization activities and equipment (reportedly some 51 different refrigerators exist, many of which were reportedly purchased by various NGOs).

d. Pediatric HIV

Given that 1% of under-five mortality in Ethiopia is attributed to AIDS itself, and HIV/AIDS may be an underlying cause in 11% of under-five deaths, special consideration must be given for this growing concern.

In developing countries, the diagnosis of HIV infection in children below 18 months is largely based on symptoms. Without recognition, delays in diagnosing HIV infection in such children may result in many dying from HIV-related illnesses before their HIV status can be confirmed by a laboratory test. Many countries do not yet have systems in place to link infants and children from the various entry points to care with the services they need. For example, mothers who participate in PMTCT programs deliver infants in settings where there may be no adequate follow-up to check the infant's HIV status; HIV-infected children in hospital wards and in the community may not be identified and thus miss out on proper care and treatment, including prevention of opportunistic infections; children seen at health facilities for immunization or other generalized care may present with failure to thrive or other recurrent illnesses but are not identified as HIV-infected.[6] Such missed opportunities may exist for integrating pediatric HIV within current child health programs in Ethiopia and thus to increase the numbers of HIV infected children on treatment.

[6] Adapted from BASICS Pediatric HIV, 2005

These opportunities could be further developed and/or expanded using existing facility and community level platforms that provide entry points for care of HIV-infected children e.g. PMTCT, IMNCI, ENA, and community health promoters (see also Section B, Pillar II). ESHE is currently exploring some of the above linkages within the limits of current programs e.g. IMNCI in health facilities, the Kokeb Kebele initiative helping orphans, but a more explicit program of work in Pediatric HIV will be needed to demonstrate impact.

Summary of Notable Achievements in Pillar I: Strengthening Health Worker Skills

- Strong technical leadership at national level for inclusion of newborn and HIV/AIDS into IMNCI; modification of training to accelerate more rapid scale-up; piloting of community based treatment of pneumonia
- Innovative approaches to expand the reach of needed child services in the community: IMNCI training for HEWs linked to Community Health Promoters, CTC linked to Community Nutrition Promoters, Immunization Diplomas for fully vaccinated children by 1 year of age
- Significant improvements in coverage with high impact interventions e.g. early initiation of BF, Vitamin A, full immunization, neonatal tetanus, reduced DTP1-DTP3 dropouts
- All of the above, linked to performance improvement activities: technical standards development, supportive supervision (with case observations), review meetings to discuss progress, H/MIS to monitor performance

3. Recommendations

Recommendation 1: Strengthen monitoring and reporting on program feasibility and effectiveness especially for newly introduced program areas including IMNCI, community based pneumonia treatment, newborn care, and CTC/CNP programs.

Recommendation 2: Promote and facilitate the adoption of ESHE 'best practices' as an FMoH standard e.g. HEW training in IMNCI linked to community health promoter activities.

Recommendation 3: Mobilize and leverage partner resources to support heavy start up costs for training and follow-on support of programs like IMNCI, ENA and EPI, using this as an opportunity to forge partnerships for scaling up these strategies in ESHE focus regions.

Recommendation 4: Explore and strengthen linkages between ESHE and programs serving as entry points for care of HIV-infected children, i.e., PMTCT, IMNCI, ENA, CHPI and Kokeb Kebele.

Recommendation 5: Strengthen referral linkages between communities and facilities to ensure that children at highest risk of dying are not lost to follow up. In ESHE, the combination of community level actions and facility-based training and supervision constitute part of a 'continuum of care' leading to improved outcomes for children. With this orientation, future programs should strengthen actions at critical points in the referral process, including quality improvements at health centers or hospitals to strengthen management of severely ill children, as well as adequate 'back referral' and follow-up in the community.

Recommendation 6: The private/informal sector is a key source of care for children. Specific strategies should be developed to engage private/informal providers (i.e. drug sellers, traditional healers) as partners in the broader system of care for children.

B. Pillar II: Improved Community and Household Practices

1. Background

In Ethiopia, there is a strong recognition that improvements in facility-based services alone cannot contribute significantly to reductions in child mortality. Access to qualified health providers or facilities is limited and many children die at home due to delays or lack of knowledge in seeking appropriate care. Pillar II aims to "strengthen positive health behaviors at household and community levels." Activities focus on changing these behaviors through a variety of outlets. Through community mobilization, individuals are nominated to become Community Health Promoters (CHP). As a CHP, individuals are empowered by Health Extension Workers (HEW) to adopt healthy behaviors as well as serve as models for their neighbors. These efforts are supported by messages shared through mass media as well as in print (Family Health Card and Immunization Diploma).

Thus far, ESHE is achieving all Pillar II targets in support of "Community support for high impact health interventions increased" (Sub-IR 14.1.1). The evaluation team anticipates that ESHE will continue to progress at planned rates and achieve all life of project targets. Progress against program-wide LOP training targets is summarized in Annex G. The impact of this growing cohort of community promoters is significant. It is assumed that not only have each of them adopted healthier behaviors but so have members of their family and even their neighbors for whom they are a model. ESHE anticipates that the cumulative effect of so many voices promoting healthier behaviors will raise the health status of first their communities, then woredas and zones and, finally, their region.

2. Discussion and Conclusions

a. Community Mobilization

(1) The Community Health Promotion Initiative (CHPI)

Much of ESHE's success in improving key health indicators can be attributed to the Community Health Promoter Initiative (CHPI). As a grassroots initiative, it has mobilized communities around health issues and energized and empowered average citizens to take control of their

health. CHPI utilizes three key activities to change the behavior of individuals and thus improve health status. First, the initiative mobilizes communities on a kebele level to raise awareness around health issues. Once oriented to the CHPI and mobilized, communities select Community Health Promoters (CHP) from among their members. CHPs are trained and challenged to implement "simple do-able health actions". As their health improves, CHPs are encouraged to model and teach these same health behaviors to their neighbors and community. Finally, CHPI links CHPs to Health Extension Workers (HEW). National Health Services Extension Program (HSEP) policy states that HEWs are responsible for coordinating all community-based volunteers. The HSEP considers that HEWs can be more effective and reach more mothers and children when working in collaboration with other community-based workers. ESHE's CHPI is one such model and it has been embraced by the GOE as an important and effective approach for reaching families with needed child health interventions. These volunteers, including ESHE CHPs, act as agents on behalf of HEWs, providing outreach, transmitting key health messages, collecting data and encouraging individuals to utilize health post and center services.

The CHPI was scaled up dramatically in year 3 of the project. Thus far 27,723 CHPs have been trained by ESHE, with the goal of training 60,000 CHPs in 64 project woredas by the end of the project. Training targets for year 3 were surpassed, except in Oromia (59% of targeted 6000 CHPs trained). If ESHE continues its current pace of recruiting and training CHPs, it will meet project CHP recruiting and training goals.

Clearly, the CHPI is a major driver in ESHE's success in specific health interventions. All three sub-evaluation teams observed considerable CHP activity in focus areas. GoE health officials at all levels of the health care system (central to post) expressed effusive support for the program. Providers and administrators attributed improvements in their respective areas of authority to the CHPI and all requested that it be rolled out within their respective areas of authority. On a community level, kebeles leaders expressed support for the initiative and many were, in fact, CHPs themselves. CHPs likewise stated that by implementing ESHE-developed "simple but do-able health actions", they noticed a change in the health of their families. This improvement, combined with the social status attributed to CHPs by community leaders, acts as a powerful incentives for increased involvement with the program. In fact, when asked how long they intended to be a CHP, in every case, the promoter stated "for life". Finally, CHPs are a key element in the HSEP. In ESHE focus areas, HEWs are increasingly dependent upon the voluntary participation in health activities that CHPs provide. CHPs not only model health behaviors and advocate for key health practices on behalf of HEWs and assist HEWs in gathering monitoring data, but they also serve a link between HEWs and the community.

(2) CHPI Impact on Health Status

As previously discussed, Community-IMCI (C-IMCI) is a major strategy for improving illness recognition, and promoting timely care and care-seeking by mothers in the community. The CHPI focuses on changing behaviors and practices by providing messages that support C-IMCI, including: immunization, breastfeeding, complementary feeding and feeding of the sick child, hygiene and sanitation, ITNs and identification and referral of severely malnourished children. The initiative is viewed as an important vehicle for introducing and sustaining these and other key family practices as part of C-IMCI. Much of the improvements cited elsewhere in this report

can be attributed in large part to the work of CHPs in their communities. During field visits, regional, zonal and woreda level officials as well as HEWs were highly supportive of this approach. CHPs themselves were extremely proud of their achievements as role models for the community. They often cited visible changes in their community such as more children coming for immunization, more mothers' breastfeeding, more latrines in the community and so forth in response. Apart from the IMNCI pilot in Bolosso Sore which included a broader array of messages being phased into CHP training, CHP messages in other districts and across the other regions did not seem to include key family practices related to the most common causes of illness. As evidenced by the 2005 EDHS, for example, coverage for simple home-based treatments like ORT is low (37%) and care-seeking for common illnesses like fever and ARI is equally poor. Strategically developed messages addressing health concerns like diarrhea (to be introduced in year 4) may expand the impact of the CHPI, but leaves little time for demonstrating sustained improvements.

Implementation Guidance: Focus on timely phasing-in and scaling-up of a set of high impact interventions that will contribute to the biggest reductions in child mortality. These so-called Lancet interventions are prioritized as part of the child survival strategy, and many are covered under the revised IMNCI curriculum for HEWs and in Family Health Cards which are being distributed widely. However, ESHE should consider phasing in more rapidly critical messages that are not yet included in all CHP training, namely treatment of diarrhea in the home as well as illness recognition and timely care-seeking for ARI/fever.

(3) CHPI as a Sustainable Initiative

Early data indicates that the CHPI is improving healthy behaviors and use of health care services in ESHE focus areas. Clearly, the CHP role is growing in import as they grow in number, and as HEWs increasingly rely on them for outreach and data monitoring assistance. As stated earlier, central, regional, zonal, woreda and health center level administrators stated a desire to expand CHPI across the country. Nearly every official interviewed by the evaluation team felt that CHPs were a key component in the health care system. However, officials also stated that they lacked the funds and staff to maintain a program like CHPI on their own.

Community-based volunteers are officially recognized within the formal health care system as delineated by the HSEP. Lack of funds and institutional human capacity to recruit, train and mentor CHPs are significant obstacles to CHPI's sustainability and to ensuring that these volunteers become institutionalized within the formal system. In Oromia's East Harange Zone, for example, the zone health officer stated that ESHE provided TOT to technical staff so that they could roll out the CHPI to non-ESHE areas, but that they had not yet moved beyond the TOT because, again, of a lack of funds. This is compounded by the fact that ESHE currently offers per diem (food and transportation costs) for CHPs to attend a two-day training at their local health center. Not only is this an additional cost, but it is acts as incentive that, if removed, could make it harder to recruit and retain volunteers. Since CHPs are becoming an increasingly integral part of the informal health care system, the failure of the CHPI could have a negative impact on health service use and, ultimately, health status.

To address issues of sustainability and support the HSEP mandate, ESHE is revising its CHP recruiting and training strategy. Instead of bringing CHPs to the woreda level for two-day trainings which are conducted by a combination of woreda and ESHE staff and HEWs, ESHE is building the capacity of HEWs (or representatives at the Health Center when HEWs are not present) to conduct trainings of CHPs in their respective kebeles. ESHE is training HEWs on how to mobilize communities and train and monitor promoter cohorts within their own kebele. TOT HEW workshops focus on promoting key nutrition and child health themes, facilitation skills and a program of regular follow-up and training of CHPs by HEWs. This new paradigm supports HSEP guidelines which maintain that HEWs manage their community volunteers. By authorizing and empowering HEWs to manage CHPs, CHPs are more likely to truly become a institutionalized within the Ethiopian health care system. With direct oversight for CHPs, HEWs will be responsible for recruiting, training, mentoring and monitoring CHPs. By formalizing the reporting structure and management/reporting role, CHPs are more fully integrated into the health care system and the initiative is more likely to be sustainable.

As stated previously, the CHP training is no longer a two-day event at the woreda level, but instead a series of meetings, lead by HEWs, in which key messages are offered one at a time. By focusing on one message at a time, CHPs are more likely to remember the material presented. Additionally, by authorizing HEWs to monitor CHPs, promoters will receive more consistent and intimate follow-up. Not only will this improve outreach efforts, but the constant contact will strengthen the relationship between HEWs and CHPs. Improved relationships will increase the connection between promoters and their local health facility. In turn, this will improve use of health care services and ideally, health status.

Shifting accountability for CHPI to HEWs will also reduce the cost burden. HEWs will train and manage CHPs in their own kebele, thus eliminating the reimbursement costs for food and travel associated with the current practice of bringing CHPs into woreda centers for training. Also, with no financial incentive associated with CHPI, promoters will more closely fit the label of "volunteers".

A HEW training line item is already included in the GoE health budget. Integrating CHP mobilization, training and maintenance into existing pre- and in-service HEW training and into the ISC will allow ESHE to share the training cost burden with the GoE. ESHE is currently working on this integration.

When CHPI was first rolled out, few HEWs had been trained and deployed. The rapid expansion of HEWs nationwide has presented a significant opportunity for rapid CHPI expansion. The majority of kebeles in ESHE woredas now have HEWs, enabling better coordination and follow-up of CHPs in the community. ESHE has responded to this opportunity by building in new program activities that strengthen HEW capacity to train and support CHPs in communities.

It is important to note that, however, links between CHPs and health centers vary and are heavily dependent on the level of involvement at the woreda level. At one health center visited by the evaluation team the nurse/midwife was unaware of the CHPI or CHP activities although CHPs were very active in several of the kebeles referring to this particular center. Since health posts and health centers report directly to the woreda level, there is no required reporting relationship

between the post and center. As a result, it is feasible that HEWs could be mentoring a cohort of CHPs of which the center is unaware. CHPs have significant potential to advocate for increased use of health center services among the kebele community. In the case of the cited nurse/midwife, she stated that her center had very few women delivering at the center. If she were to utilize the CHPs, they could encourage women to deliver at the health center. Increased attention to the relationship between not only the HEW, health post and CHP, but to the HEW as a link between the CHP and health center, is important and could increase use of health center facilities and services.

ESHE should continue to use HEWs to strengthen links between health centers and CHPs and ensure that all health center staff is aware of and use CHPs for health promotion as well.

(4) Scaling up the Community Health Promotion Initiative

With its inclusion in the Health Sector Development Plan III and the Health Services Extension Program guidelines, a framework exists to take the CHPI nationwide. Moreover, if the model of using HEWs to train CHPs that is presently being studied in Oromia region proves successful, it could provide a platform for more rapid expansion. This model would also reduce the level of resources required to expand the CHPI beyond the 64 woredas where ESHE currently works.

The evaluation team asked ESHE staff to estimate the costs associated with using this approach to expand the CHPI, based on project experience to date. The estimate provided by ESHE for a "typical" woreda/district follows.

District A has a population of 250,000. It has 35 kebeles. On average, each kebele has 2 HEWs with 30 CHPs per kebele. In total, there are 75 HEWs and 1,050 CHPs in the district. To implement CHPI, the following will be needed:

- Orientation of zone/woreda to the approach
- Master TOT of woreda and health facility staff, and selected HEWs
- TOT for HEWs
- Support for community orientation
- Review meeting for HEWs (6 months post TOT)
- Training materials
- BCC materials (Family Health Card, Immunization Diploma)
- Complementary Feeding Counseling Tool
- T-shirt for CHPs

Total cost of start-up is US$13,624 (ETB 8.7 = US$1). This is an estimate for 1 year for a woreda of 250,000 population. This takes into account actual implementation costs. No general support costs are included. Recurrent costs are required for the BCC materials, and follow-up meetings with HEWs, and ongoing trainings due to staff turnover.

The minimum requirements to expand the CHPI include: a) HEW capacity to recruit, train, and manage community volunteers; b) a woreda-level pool of facilitators and staff for TOT training and supervision of HEWs and CHPI (to date, high woreda staff turnover has resulted in the need for repeat orientations and trainings); and supply and distribution of training and BCC materials, including the TOT Manual, HEW Handbook for training and mentoring CHPs, Family Health Card, and Immunization Diploma.

(5) Coordination of Community Volunteer Programs

Several different cadres of community workers currently co-exist throughout the regions. Community health workers (CHW) were previously given formalized training which included curative services in the community. Traditional Birth Attendants (TBA), Community based reproductive health agents (CBRHAs) and Community Resource Persons (CRPs) received varying degrees of training across a range of similar topics using different types of program frameworks, materials, incentives and support. The head of the HEP program is keen to standardize guidelines for creating "CHWs for all" and to see the existing models evaluated for their cost-effectiveness, feasibility and impact.

In addition, donors and international organizations also support different types of community health volunteers and promoter models. Selection criteria, roles, and incentives vary both within USAID-financed programs and across donors.

For example, Pathfinder recruits, trains and deploys community-based reproductive health agents (CBRHA) and presently has over 10,000 CBRHAs active in 278 woredas. Similar to ESHE, volunteers are selected by kebele community committees. Volunteers participate in a two-week training course in family planning and reproductive health and then return to their community to promote family planning method use and distribute family planning methods. While CBRHAs receive some direction and mentoring from HEWs, they are primarily supervised by Pathfinder's NGO subgrantees.

CHWs, regardless of their focus, are essential to the success of the HSEP. ESHE and Pathfinder are operating in many of the same woredas and promoting health behaviors that are mutually supportive. As a result, it is vital that their messages not compete with or undermine each other. Additionally, each project has different eligibility requirements, incentives, and training curriculums in place for volunteers.

Implementation Guidance: In order to ensure that volunteers are trained and deployed in a sustainable fashion that supports HSEP, the evaluation team recommends that ESHE and Pathfinder harmonize approaches, messages and incentives. The CHW volunteers, as a subset of the Ethiopian health care system, are growing in importance and thus collaboration between projects is essential.

In another example, UNICEF is piloting a community IMCI promoter (C-IMCI) initiative. The pilot is expanding into 30 districts. Under this initiative, Community Resource People (CRPs) are responsible for progressively introducing the 20 key family health practices in the communities they serve. As for the CHPI, HEWs are being trained as trainers and supervisors of

CRPs. Under the next country program, UNICEF will expand this initiative to 300 woredas, some in non ESHE woredas within the USAID focus regions. The C-IMCI Initiative has several notable differences which could, as both donors scale-up their respective promoter initiatives, pose significant hamonization issues. UNICEF requires that their promoters are literate and training per diem and farming materials are just a few of the incentives provided to promoters.

In Tigray, a strong history of volunteerism and government-owned initiatives has resulted in the training, by the Regional Health Office, of some 2500 community health workers. These CHWs are taught to provide promotive and preventive services including immunization, ORS, breastfeeding, first aid, etc. As in the CHPI, the community volunteers do not provide curative care and also, the link to HEWs is being strengthened.

Elsewhere, in one district in Amhara, CARE is implementing a program within the C-IMCI framework. It includes skill development of health staff and various community health cadres, community mobilization, BCC, quality assurance (using COPE), and supportive supervision, among others.

Implementation Guidance: Assist the FMOH to identify and compare the various community health volunteer models currently in use in Ethiopia for child health programs to inform discussions of scale up. Many different types of community-based volunteer models exist, even within USAID-financed partner organizations. ESHE is putting considerable funds and technical assistance into exploring the possibility of scaling up CHPI. Before doing so, the evaluation team recommends that ESHE and USAID review and compare the costs, strengths and weaknesses of its current or planned models as a basis for initiating discussions with the GOE and other donors. Further, ESHE should consider ways to assist the FMOH to evaluate the existing models for their cost-effectiveness, feasibility and impact.

b. Behavior Change Communication

ESHE BCC materials utilize a variety of mediums to educate and encourage adoption of key health practices among individuals and communities. These materials are also used to promote increased use of the health services available at facilities. Two primary mediums for dissemination of BCC materials are print and radio.

ESHE print materials, primarily distributed by CHPs and other health facility providers, include the Family Health Card (FHC) and the Immunization Diploma (ID). Users touted them as "extremely useful in helping people learn how to be healthy". Evaluators found that in ESHE kebeles the FHC and ID were widely available and used. Even illiterate community members were able to produce the FHC and use the illustrations to accurately explain health behaviors as promoted in the materials. These same individuals also indicated that they reviewed the FHC with their family and that the CHPs used them as a reference text when promoting. The ID is also considered a significant incentive for many ESHE focus area community members in ensuring that their children are immunized. The evaluation team observed IDs hanging in individual homes and providers felt that it served as a significant reminder to individuals of immunization series appointments. The community approval that ID awardees received when their children completed the immunization series also created a powerful positive incentive and

example for other community members. Interviewed providers at all levels felt that, as BCC materials, the FHC and ID effectively supported provider and CHP efforts to improve healthy behaviors in community-level individuals and families. As such, with the help of UNICEF, the ID and FHC have been printed and disseminated to non-ESHE areas.

According to assessments including the DHS, radio listenership in Ethiopia is significantly higher than radio ownership. More stations generate more listeners, as noted in SNNPR following creation of a new FM station. Given that Ethiopia is predominantly rural and illiteracy is still an issue, radio has the potential to play a pivotal role in delivering messages. That said, according to the 2005 DHS, only 16 percent of all women (10 percent rural listeners) and 31 percent of men (26 percent rural listeners) "listen to the radio at least once a week". When informants were asked if they had heard a radio spot, many replied in the negative. In other areas, Oromia for example, the zonal health office head replied that there were local radio stations that were not being utilized by ESHE. Evaluators are unsure if he had not heard the spot or if radio spots are, in fact, not aired on this zone's local stations. It is not clear, however, that radio BCC is an effective medicum for reaching communities and changing behaviors.

Summary of Notable Achievements in Improved Community and Household Practices

- 27,723 CHPs trained;
- over 1,600 kebeles with trained CHPs.
- Key health behaviors adopted as a result of CHP activities.
- 106 instructors trained in community mobilization.
- 77% households in ESHE focus areas were visited by CHPs in year 3.
- 300,000 FHCs and 237,000 IDs printed and distributed by ESHE. 1.3 million ID printed with UNICEF funds and co-distributed with ESHE.
- 38% of fully vaccinated children received the ID and 57% households have FHC in ESHE focus areas in year 3.
- Increased application of healthy behaviors promoted attributed to materials.
- 72 radio journalists/producers trained in year 3.

While ESHE has trained providers and administrators at all levels of the health care system to use the FHC and ID, the evaluators feel that they do not have the capacity to develop print materials on their own. Since the evaluators did not interview any radio journalists they are unable to comment on their capacity to independently develop radio messages.

Implementation Guidance: ESHE should continue current print activities aimed at disseminating and using the FHC and ID. Clearly, the developed print materials are effective and widely used. To expand their use, ESHE should ensure that these materials are available at

all points of entry into the health care system. For example, many Ethiopians go first to pharmacies for initial diagnosis or medical care. Educating pharmacists on the FHC and ID and coaching them on how to promote the materials could further increase adoption of health behaviors. The evaluation team also supports recommendations offered in the recently completed "Qualitative Assessment through Focus Groups and Individual Interviews of ESHE Behavior Change Communication Community Interventions" document including that to introduce materials into the educational system.

Implementation Guidance: Conduct an assessment examining the relative impact of radio messages, spots and programs on health behaviors. It may be that other BCC channels are more cost-effective vis-à-vis impact.

3. Recommendations

Recommendation 7: USAID should initiate a dialogue with the GOE and other organizations financing community-based volunteers with the objective of harmonizing approaches where possible. Harmonization of the various approaches is needed at national as well regional and zonal levels. To assist in that process, models should be evaluated for their cost-effectiveness, feasibility and impact. USAID is a member of two national-level health sector coordinating committees which could serve as the vehicles to launch this dialogue.

C. Pillar III: Improved Health Systems

1. Background

Health expenditures in Ethiopia have historically been low. In 1996 and 2000, per capita health expenditure was only $4.5 and $5.6, respectively. This figure has steadily risen to $7.14 in 2004. Recognizing the chronic under-funding of the health care system, the MOH, through the HSDP III, is focused on increasing resources to the health sector, improving efficiency in resource allocation and utilization, ensuring sustainability of financing, and improving the quality and equity in delivery of health care services.

Ethiopia's health system is highly decentralized. Over the last 10 years, the Government of Ethiopia has undergone a series of decentralization reforms that devolved responsibility to the district (woreda) levels. Thus, the Federal Ministry of Health (FMOH) and the Regional Health Bureau is largely responsible for steering policy. The Woreda health offices play the pivotal role of managing and coordinating the operation of primary care services.

2. Discussion and Conclusions

a. Health Care Financing Reform

ESHE supports the implementation of the Health Care Financing Strategy adopted in 1998 to bring structural changes in the Ethiopian health sector. The health care financing reform package includes the following elements: authorization of health facilities to retain revenues generated; revision of the fee system; decentralization of health facility management to the

Health Management Board; authorization to outsource non-clinical activities; improvements to the system of waivers and exemptions; and initiating health insurance schemes.

(1) Legal Framework (National)

ESHE has worked with the MOH to develop a legal framework to support its health care financing strategy. ESHE has provided technical assistance by conducting studies and developing concept papers. While ESHE has provided strong and consistent support in this area, the legal framework at the national level has still not been ratified by the GOE. Understandably, many of the factors that have kept the GOE from passing the legislation have been well beyond the control of the ESHE project.

ESHE's approach in supporting the legal framework has had mixed results. Our interviews suggest that ESHE is seen as a critical body by the MOH to provide analytical support to the health reform process -- a testament to the fact that this capacity does not fully exist in the GOE. ESHE has met the GOE's expectations in that role by producing critical analysis and assistance on health reform. However, the reform process is a long and continuous one, and it is equally important to develop local capacity to lead and manage the reform process. ESHE has not yet succeeded at developing local capacity to independently lead and manage the NHA process. Again, high MOH staff turn-over has been a major challenge for ESHE -- an issue well beyond the project's control. At the same time, although training and supportive supervision have had a positive impact on developing capacity, it does not appear that GOE capacity development has been the primary objective under this program component.

Implementation Guidance: The evaluation team recommends that ESHE, rather than directly providing input should focus on training and supporting GOE counterparts to provide this input. The newly established Health Care Financing team within the FMoH may be an ideal place to focus these energies. It is important to note that a by taking a purely capacity development approach, it may take longer to provide inputs to the government, and certain "windows of opportunity" may be missed. However, in the long run, this approach will strengthen the GOE's ability to manage the reform process.

(2) Legal Framework (Regional)

Similar to their efforts at the Federal level, ESHE worked in Oromia, Amhara, and SNNP to develop regional legal frameworks. Our interviews indicate that ESHE worked in a highly collaborative and consultative manner to ensure that the draft proclamation, regulations and directives were reflective of the Government's desire. In all three regions, ESHE's support resulted in the successful passage of the proclamations and regulations. The directives were passed in SNNP and are in their final stages in Oromia and Amhara. ESHE's work has even spilled over into non-ESHE regions, as Tigray and Addis Ababa have ratified their respective Regional Proclamations. Noting the importance of this, the project has even gone as far as offering limited technical assistance to these regions.

The passage of the regional legal frameworks is a significant achievement for ESHE. This framework dramatically changes the health financing picture, by allowing for user-fee retention,

contracting, hospital autonomy, and other major changes. If properly implemented, these changes could increase resources for primary care (and child health) and lead to increased quality of care.

Our interviews indicate that ESHE was one of the prime driving forces in passing the legal framework. According to Dr. Shiffero, director of the SNNP regional health bureau, "If not for ESHE's support, there is no way I can see health care finance progress in this country. That is the bottom line."

Similar to their approach at the Federal level, ESHE's highly motivated staff may have taken on too many of the tasks needed to develop and pass the legal framework. In Amhara, some senior officials expressed concerns that ESHE was too heavily involved in advocating for the development and passage of the legislation. As discussed in the previous section, the health reform process is a long and continuous one, and it is imperative for the regional governments to have the capacity to make continuous improvements to the policy framework. Given the decentralized nature of Ethiopia, this capacity cannot be limited to the central level – it must exist at the regional level as well.

Implementation Guidance: The evaluation team recommends that ESHE work with RHB's to establish an organizational entity, similar to the Health Care Financing team within the FMoH at the central level, responsible for providing analytical input into the policy process. ESHE is well-placed to for this activity given its collaboration with RHB counterparts throughout the policy development process. Our interviews suggest that there is political will for such an entity, and thus this activity should require a limited amount of effort to achieve success.

(3) National Health Accounts (NHA)

Although NHA was not the central focus of health sector reform efforts under ESHE, it supported those reforms by generating evidence and information for policy advocacy.

Ethiopia has undergone three rounds of National Health Accounts, with support from ESHE for rounds 2 and 3. Our interviews with senior MOH officials suggest that the first round of NHA were primarily donor-driven, and not routinely used by the GOE for planning or decision-making. However, with the second and third round of NHA, ESHE has stimulated comparatively more GOE interest and utilization of NHA, primarily through dissemination and communication activities. Our interviews reveal that many of the targets set in the HSDP 3 were based on findings from the ESHE-supported NHA exercise. Those interviewed felt that the NHA has added transparency and rationality to decision-making. The MOH declared that per capita health spending should be increased from $7.18 per capita to $9.6 by 2009 – a 25% increase in health spending. This is a significant and high-impact achievement that will bring much needed additional resources to the health sector.

That said, NHA has still not been fully institutionalized in Ethiopia, and still will require significant technical assistance to continue in the future. ESHE has made an effort to develop local capacity by conducting trainings on the Producer's Guide to NHA and by collaborating with the Federal and Regional Governments for the data collection process. However, ESHE was

not able to fully engage the GOE in the analysis of the NHA – the majority of the analysis was done by ESHE and PHR Plus staff. Additionally, there was no established unit within the MOH that was responsible for the NHA, as it was perceived that the NHA was a donor activity.

The planning department of the MOH has recently established a Health Care Financing Team within PPD that currently has three staff and may grow by several more in the near future. This unit was established to take on critical health systems analytical work, including NHA, health finance reform analysis, and insurance analysis. The establishment of this unit, and its mandate to carry out NHA, is a significant step towards institutionalization of NHA.

Implementation Guidance: The evaluation team recommends that, in the area of NHA, ESHE works exclusively on fully institutionalizing the NHA. First, ESHE should work on training the staff of the PPD Health Care Financing team on how to conduct a full NHA exercise. Second, ESHE should work with the GOE to set a timeline for total capacity transfer, with clearly defined benchmarks that demonstrate a phase-out of ESHE support and a phase-in of GOE capacity.

(4) Special pharmacy guidelines at central level

Chronic under-funding of budget pharmacies has left many health facilities without essential drugs. The GOE, together with partner institutions, established over 300 revolving drug funds at many health centers, so that the facilities could procure and manage their own supply of pharmaceuticals. The surplus generated by the pharmacies is to be used to finance quality improvements in the health facilities. Interviewees consistently expressed the opinion that the special pharmacy initiative has been an important step in improving the quality of health services.

ESHE was a key player in development of the Special Pharmacy project and provided direct support for creation of the first 150 pharmacies. ESHE also helped develop National guidelines and supervisory checklists, trained pharmacy staff, and provided supportive supervision for the initiative. The guidelines and supervisory checklists have been well received by the GOE, and serve as an important mechanism for monitoring the pharmacies. At some of the sites visited by the evaluation team, the regulations were not always followed and supervision was not routinely conducted. In some cases, such as the Awasa Health Center, the special pharmacies appeared to be functioning well, and surplus was invested in quality improvements such as a waiting room area with BCC messaging on safe motherhood and child health. At other sites, however, the teams found the opposite: poor management leading to slow procurements, procurement of expensive branded drugs over generic equivalents, and poor reinvestment of surplus. In some areas, privately-run rural drug vendors, who felt threatened by the special pharmacies, posed strong resistance to the special pharmacies and its managing board members. Although the team recognizes that the small number of sites visited may not be representative, its observations are similar to those in the World Bank Country Status Report conducted in 2005.

Implementation Guidance: Team interviews indicate that the special pharmacy initiative will soon be merged with the budget pharmacies and the retained revenue from user fees. However, there are useful lessons that should be captured from the special pharmacy initiative that will be particularly important for the implementation of user fee revenue retention. ESHE should capture

the best-practices in 1) managing revenue from special pharmacies; 2) re-investing revenue for quality improvements; 3) good governance of revenue, including how to develop strong management boards; and 4) administrative issues with retained revenue.

(5) Health Care Finance Implementation Trainings

The implementation of legal framework should be the key priority for ESHE for the remainder of the contract period. ESHE has already developed a health care finance implementation manual, and has conducted several 'training of trainers" (TOT) workshops. The TOT workshops have included over 80 participants from every Zone in both SNNP and Amhara, regardless of whether the zone was ESHE-supported or not. In ESHE-supported areas, the TOT participants went on to conduct trainings for a total of 171 health finance staff in their woredas. The workshops and health care finance implementation manual are well designed and critical components for implementation of the reforms, and have been well received by the RHBs.

Since the legal framework will affect both ESHE and non-ESHE woredas within a given region, it is imperative that the implementation of the legal framework be consistently executed throughout the region. ESHE has long recognized this, and has attempted to support as many non-ESHE woredas as possible with its limited budget. Even still, we find that implementation in ESHE-supported Zones and woredas is moving much more systematically and successfully than those not supported by ESHE. This was highlighted in the non-ESHE site visited by the team, in which the woreda Health Office was unsure about its role in implementing the Proclamation and had been reluctant to allow health centers spend retained fees due to poor guidance. It is important to qualify these observations with the fact that the implementation has just recently begun.

The team finds that the TOT approach is not enough to ensure region-wide implementation. Successful implementation in ESHE-supported regions can be attributed to consistent support to trainers throughout the implementation process – not just TOT.

Implementation Guidance: The assessment team recommends that ESHE should work beyond the TOT activity to ensure implementation of the legal framework by also providing 'end-user' training support in non-ESHE woredas. Given the limited financing available to the project, ESHE should find cost-sharing mechanisms with other partners or the GOE. One approach could be to support trainers in running implementation training workshops that include participants from all woredas in a given Region, with financing from the RHB for non-ESHE participants. By adopting a cost-share approach, ESHE will also help build GOE institutionalization of the implementation activities.

Summary of Notable Achievements in Health Care Financing

- Far-reaching legislative reforms to increase quality of care and availability of resources for primary care ratified and implemented in four regions (including Tigray). All Waredas in each region impacted, regardless of ESHE support.
- Establishment of Health Policy and Economics Unit in MOH to take over NHA, MBB, and other policy analysis work.
- Highly collaborative approach with regional governments to help develop legislative reforms
- Support of NHA resulting in MOH declaration to increase health spending by 25% by 2009. NHA data routinely used to set targets in the HSDP III.
- Highly effective training materials on how to implement health reforms developed

(6) Linking Child Health and Health Systems

Many of the achievements of the health care finance component of the ESHE project have implicitly served to improve child health. However, these linkages have not been explicitly drawn between the various components of the project. Moreover, the projects mandate in health systems clearly extends beyond child health. For instance, retained revenues can also be used to make quality improvements in maternal health, family planning, HIV/AIDS, TB, Malaria, and other primary care. Thus, the HCF component of the project has had to struggle to serve child health while its activities clearly benefited primary health care as a whole.

Implementation Guidance: Conduct limited analytical work to explicitly link work in health systems to improvements in child health. These linkages can help prioritize activities for ESHE. Moreover, an explicit exposition of these linkages can add further clarity to other programs beyond ESHE that are attempting to draw direct links between health systems strengthening and health service outputs.

3. Recommendations for Health Care Financing Reforms

Recommendation 8: Focus on capacity transfer to GOE
ESHE's technical approach for the remainder of the contract period should be to foster capacity transfer. Though much has resulted from ESHE's work on NHA, MBB, many policy studies, and implementation support for the legal framework, much of the capacity to conduct these exercises still does not lie with the GOE. ESHE should work with the GOE to develop an explicit and realistic timeline along with progress benchmarks to transfer these capacities. ESHE should identify core groups within the GOE where capacity transfer could be most successful, such as the PPD Health Care Financing team in the MOH. Moreover, ESHE should explore cost-sharing arrangements with the GOE to foster greater institutionalization of activities, such as legal framework implementation trainings.

Recommendation 9: Focus on implementation of legal framework
In the area of health sector reform, ESHE's focus to date has primarily been on passage of the legal frameworks. As the legal frameworks have already been or are nearly passed in all three regions, ESHE should focus on helping regions implement the directives. Many of the components of the legal framework, such as contracting, hospital autonomy, and hospital private-wing are complex in nature and will require significant training at all decentralized levels. Given the limited resources available to ESHE in the final two years of the contract, ESHE should develop a strategic approach to TOT and end-user training support that leverages other sources of finance, such as GOE cost-share. Finally, as discussed in the previous section, it is important that ESHE use a capacity-transfer approach, as the implementation process will long outlive ESHE support.

Recommendation 10: Ensure optimal use and oversight of retained revenue
Though a sub-set of recommendation two, we mention the optimal use and oversight of retained revenue as a separate recommendation due to the critical nature of this activity. We recommend that, in the area of health care finance, the ESHE project devote the majority of its resources to this area. These fees, combined with revenue from the special pharmacies, represent a significant amount of resources that can be used to improve the quality of care for child health and beyond. It is critical that these resources are spent effectively so that high-impact quality improvements can be achieved.

To accomplish this, ESHE should focus on several key areas. First, the project should help health facilities develop the capacity to administer and manage retained revenue. Second, the project should work to strengthen the ability of health facility planners to develop strategic plans on how to best allocate retained revenue. This involves building upon ESHE's previous work on using HMIS for decision-making as well as the MBB tool. At the same time, the project should ensure management committees, which oversee health facility expenditures, are clear on their roles, responsibilities, and regulations. It is particularly important that the civil society member of the committee be trained on his/her role of serving as a conduit between the community's preferences and the boards spending patterns. Additionally, ESHE can help develop a regular reporting mechanism between the committee and the woreda, so that adequate oversight of the committee's actions is in place. This would also involve developing performance standards and a supervisory system to monitor key functions such as use of revenue and financial management. Finally, ESHE may wish to consider helping RHBs develop a recognition system for high-performers and best-practices. Again, the approach to these activities should be that of capacity transfer.

Recommendation 11: Scale-up to non-ESHE woredas
The ESHE project has achieved an impressive array of results in the health finance and systems area. Not surprisingly, most of these results have been realized in ESHE-supported woredas. There have certainly been spill-over into non-ESHE regions, though often not in a systematic and organized manner. The evaluation team recommends that ESHE develop a strategic and deliberate approach to disseminating knowledge to non-ESHE woredas and Regions. The team recommends that ESHE work through both governmental and non-governmental entities operating in non-ESHE regions for dissemination. As mentioned earlier, ESHE should also

Ethiopia: Pathway to Social Health Insurance

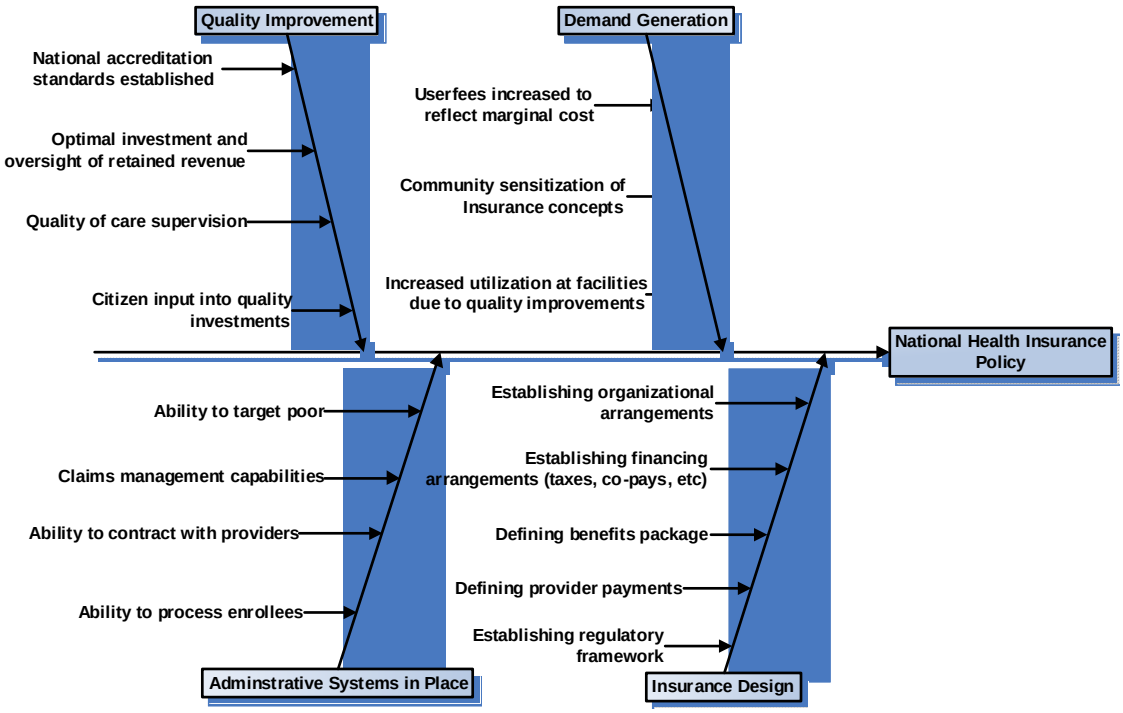

Figure 1. Though not comprehensive, this pathway represents several of the fundamental steps towards establishing national health insurance in Ethiopia.

explore cost-share arrangements with GOE and leverage other partners to ensure that cross-cutting systems activities are successful in non-ESHE areas.

Recommendation 12: Support building blocks of social health insurance
USAID/Ethiopia is currently assessing its strategy on support for national health insurance in Ethiopia. At the same time, USAID/Ethiopia has always supported the basic building blocks of insurance. Figure 2 represents the assessment team's view on the pathway to social insurance in Ethiopia. Though this pathway is not comprehensive and will require further assessment, we believe that ESHE is well positioned to provide support to several of these building blocks.

Specifically, ESHE should continue support in the areas of 1) Quality of care supervision; 2) Optimal use and oversight of retained revenues; 3) Citizen input into quality improvements; 4) Ability to target the poor; and 5) User fee revision to reflect marginal cost of services and willingness-to-pay. Strengthening these areas will be instrumental to ensuring health facility autonomy and financial viability and, hence, the eventual development of social health insurance in Ethiopia.

b. Performance Improvement

In order to improve the capacity and performance of providers and health system managers, ESHE is working through a variety of outlets. According to the ESHE baseline studies, many front-line providers were misdiagnosing diseases and/or inappropriately treating them. One cause for this was a lack of performance standards and protocols. Performance was also negatively affected by limited supervision. Similar gaps existed in facility management. Mismanaged resources, poor personnel management and lacking planning skills contributed to poor performance as well. Without the management systems in place to address poor performance and recognize good performance, data collected indicated that quality of care suffered as providers floundered. Only 47 percent of facilities received supervisory visits and, of those, 6 percent received a visit that included direct observation of case management. Providers were not receiving the level of supervision and on-the-job training and resources necessary to ensure that high quality of care was being offered.

ESHE responded to these gaps by developing systems and activities focused on improving performance both technically and managerially. Key activities address: developing supportive supervision systems, implementing standards of performance (service delivery and management), strengthening the Health Management Information System (HMIS) and institutionalizing review meetings. Each component helps create a comprehensive system of management and organizational strengthening for those working within the health care system.

Performance Improvement component life of project targets, as described in the ESHE monitoring and evaluation plan, are being met and progress is being made towards "Quality of health services improved" (Sub IR. 14.1.3). Over the last three years ESHE has systematically developed and implemented the four above mentioned activities with the ultimate goal of improving quality of care. Service delivery standards and protocols are in place and being used. ESHE focus areas are implementing the supportive supervision approach. Through training and systems strengthening, HMIS is being used as a decision making tool with increasing frequency. Finally, review meetings have become status quo in ESHE areas. While room for improvement remains, the evaluation team anticipates that ESHE will attain all life of project targets.

(1) Supportive Supervision

Supportive supervision is a major component of ESHE's performance improvement package of interventions. An integrated supervisory checklist (ISC) was developed by ESHE for all levels of the system along with guidelines for conducting supportive supervision. These guidelines and tools were disseminated through training at regional, zonal, woreda and health center and post levels. Some 551 staff across the 3 regions was trained by the end of year three. ESHE has supported the application of the supportive supervision model through on-the-job coaching in joint ESHE-woreda supervisory visits. Notably, regional level training included participants from non-ESHE zones and several zones have disseminated ESHE's supportive supervision guidelines, forms and techniques to non-ESHE focus areas. Finally, ESHE has been working at regional and zonal level to include quarterly supervision visits in their annual work plan.

From discussions with staff, supportive supervision is carried out and is considered quite useful. Some regions reported that this form of supervision gave them a sense that health centers were better managed and were providing better quality care. Many found the approach supportive, as designed, and not fault-finding as with prior supervision models. The ISC seemed to be widely utilized and supervision feedback/comments are being captured at various levels. All using the ISC reported that it is a helpful tool and used for initial and follow-up performance evaluation. Some health centers fund the supervision of health posts on a monthly basis with their own funds and even stated that they would continue using the ESHE model and tools even without ESHE's presence. Supervision costs were also being shared in some regions, with half of quarterly visits supported by ESHE, the other half covered by regional or zonal health budgets. The approach was not operational in one zone visited but this was likely due to new staff at the zonal office.

The team also observed that the ISC is in English. In many cases the forms were also completed in English. The evaluation team found that at health center and post levels, however, staff spoke limited English. In order to ensure that the ISC was fully utilized, some zones and woredas are translating the form into Amharic on their own.

Implementation Guidance**:** The evaluation team recommends translating the ISC into Amharic, and other languages where appropriate. Not only would this ensure that those being supervised fully comprehend their reviews, but it is more rational to do the translation once at a central level to avoid duplication of effort and to ensure consistency and accuracy of translation.

Implementation Guidance: In some areas the supervision is seen as an ESHE-driven activity and phrases like "when ESHE comes to supervise…" would preface discussions. In the remaining two years, ESHE should assist regions in developing plans for institutionalizing and sustaining the supportive supervision model.

Implementation Guidance: As part of a broader performance improvement mandate, ESHE should continue to strengthen but also institutionalize the capacity of health staff to do self-assessments and monitor their own quality and performance, especially between quarterly supervisory visits.

(2) Standards of Performance

Start of project baseline surveys found that neither management nor service delivery standards were consistently used or available at any level of the health care system. Without standards, quality of care is impossible to improve on a standardized basis. Over the last three years, ESHE has developed and disseminated both service delivery and management standards. With these standards in place, facilities and staff have a baseline from which to measure and improve performance.

Evaluators found that service delivery standards were readily available. In health posts, for example, standards were written on paper and posted on the wall. Nearly every site also had a plastic file sorter, usually on a desk, in which ESHE manuals were placed. Providers stated that

they used the service delivery performance standards. However, adherence to standards was not easily validated since no providers were observed providing care.

Evaluation teams from each region reported varied responses when providers were questioned about ESHE management standards. In Oromia, providers had management standards readily available whereas in Amhara evaluators found that most of those interviewed were unable to produce them. As in the case of the service delivery standards, it was difficult to determine the extent to which management standards were used in those sites where they were found.

Finally, both the service delivery and management standard protocols are printed in English. While most health care providers speak some level of English, the evaluation team found that actual ability to function in English was variable and often minimal. Again, some sites have begun the translation process on their own.

Implementation Guidance: The evaluators recommend that ESHE place increased emphasis on the application of the management standards. Since management standards are included in the ISC, regularly scheduled supervisory visits are an ideal forum in which to bolster the use of management standards, allowing the supervisors to verify that standards are being applied and coach in their use when they were not.

Implementation Guidance: The team recommends translating all standards into Amharic, Oromiffa and other languages where appropriate in order to maximize their use. ESHE must work with the appropriate officials to ensure that translations are standardized and correct. Ad hoc translation of service delivery and management standards of performance guides will undermine the "standard" nature of the document and thus the documents' value.

Implementation Guidance: ESHE should explore the feasibility of integrating developed service delivery and management standards into pre-service training for all types of health care providers.

(3) Review Meetings

Review meetings are a key tool in improving the performance of health care providers. During these regularly scheduled meetings, health care providers and administrators meet to identify areas of service or facility management in need of improvement, share best practices or lessons learned from past attempts to address these or similar issues, and decide on actions to address these trouble areas. These meetings are also used to conduct fiscal and management planning. ESHE provides technical support in assisting health facilities plan and carry out regularly scheduled review meetings and follow up on key action items. The underlying principle in holding these meetings is that performance and quality of care improves as obstacles are identified, solutions proposed and subsequent successes or failures are shared and leveraged.

Those interviewed identified review meeting as effective forums for planning, sharing best practices and troubleshooting obstacles in both service provision and facility management. At regional, zonal, woreda and facility levels, review meetings are held on a scheduled basis. In many sites, schedules were posted on the wall. Meeting minutes were kept and referred to on a

regular basis. Providers and administrators felt that the review meetings provided an effective management tool for ensuring that performance appraisal recommendations for both personnel and facilities were implemented. The evaluators found that staff used the review meeting as a forum for discussing obstacles to improved provision of quality of care and proposing solutions to these obstacles. Many improvements in service delivery are attributed to the ideas generated in review meetings. Review meetings were also viewed as a venue for discussing care targets (i.e. DPT3 coverage), HMIS data and standards of care. At regional, zonal and woreda levels, administrators stated that, as a result of ESHE training and coaching, they felt capable of managing the review meeting process on their own. They also stated that they intended to implement the practice in non-ESHE areas.

Implementation Guidance: ESHE should consider adding (or bolstering where already added) a technical training element to the agenda for review meetings. Since review meetings bring together various groups of staff at the same time, they are an ideal forum in which to offer in-service trainings, even if only compromised of a five minute refresher message (i.e. introduce new performance standard, practice using new equipment, review the importance of a health intervention).

(4) Health Information Systems

Improving the performance of the health management information systems (HMIS) has been a key priority for the GOE. ESHE has worked on both improving the quality of HMIS data as well as using the HMIS data for decision-making. This activity

To improve the HMIS reporting process, ESHE has helped Regional governments to: 1) standardize and make concise the reporting format of forms at all levels; 2) develop a supervisory checklist to help woreda, zonal (SNNP), and regional officials monitor HMIS performance; 3) develop quality assurance boards at the Zonal level; 4) train 200+ health staff on HMIS; and 5) develop an audit system in which woredas and regions have the ability to conduct random checks of data to ensure quality. Through interviews with health workers, the assessment team found that the supportive supervision approach has been highly effective in motivating health workers to report accurate data. The assessment team also heard unanimously positive feedback from supervisors on their improved ability to monitor HMIS as a result of the supervisory checklist.

To improve the use of data for decision-making, ESHE provided trainings to health managers on how to use HMIS data for planning. The assessment team found that these trainings have been highly effective. Health facilities, woredas, and Zones (SNNP) in all three regions used HMIS data to set targets, and prominently displayed performance against targets on wall charts. All three regions used HMIS data to develop their annual plan. In Amhara, several health center planners mentioned that they used HMIS data to help plan use of retained fees. On the whole, however, the use of HMIS for budgeting and advocacy is still limited.

Summary of Notable Achievement in Performance Improvement

- 551staff trained by the end of year 3 in supportive supervision techniques and tools.
- Integrated Supervisory Checklist developed and implemented in all ESHE focus areas.
- Many zones are rolling out the supportive supervision process and checklist to non-ESHE woredas
- Service delivery standards are readily accessible at all facility levels.
- Review meetings touted as an effective forum for addressing service delivery gaps.
- Many zones are rolling out the review meeting process to non-ESHE areas.
- Highly innovative approach to strengthening HMIS, resulting in SNNP winning 'best practices award'. ESHE's integrated approach involves supportive supervision, quality assurance boards, random audits, and performance incentives.

Of noteworthy mention, ESHE supported SNNP in their highly innovative performance-based system to improve HMIS, in which woredas that perform well relative to their targets receive bonuses such as motorcycles for conducting supervisory visits. This system has shown to be highly effective, and SNNP was recently awarded a "Best Practice Award" by the MOH for its practice.

D. Program Level Topics

1. Project Relevance to GOE Priorities

The Government of Ethiopia health development strategy is laid out in the Health Sector Development Program (HSDP), currently in its third five-year cycle, HSDP III. HSDP III focuses on primary health care and preventive services, with plans to extend outreach services to outlying villages and households and achieve universal primary health care coverage by the year 2008. Two major components of the HSDP III are of particular relevance to the ESHE project. The first of these is the Health Services Extension Program (HSEP), which plans to deploy 30,000 female health extension workers at the rural health post level by 2008. HEWs provide outreach services and are responsible for delivering 16 health care interventions and messages in four areas: hygiene and environmental sanitation; disease prevention and control; family health services; and health education. The second component is the national Health Care Financing Strategy, which aims to increase resource flow to the sector, improve efficiency of resource utilization, and ensure sustainability of financing to improve the coverage and quality of service.

Under HSDP III, the health sector will focus on extending preventive health services to those who have not yet been reached, and improving the effectiveness of services, especially addressing difficulties in staffing and the flow of drugs. By 2008, the strategy aims to: reduce under-five mortality from 140 to 85 per 1000 population and the infant mortality rate from 97 to 45 per 1000 population; cover all rural localities with the HSEP to achieve universal primary health care coverage; reduce morbidity attributed to malaria from 22 percent to 10 percent; and reduce the case fatality rate of malaria in children under five from 5 percent to 2 percent.

ESHE has both played a central role in the development of HSDP III and has adapted its activities to closely align with national health sector policy. ESHE participated in the design and costing of HSDP III, and was an active member of the Child Survival Partnership which provided technical input for development of the Ethiopia National Child Survival Strategy in 2005. As well, ESHE has contributed to implementation of HSDP III through technical assistance at all levels of health services delivery, most importantly, community-based services and programs. In each of its three focus regions, ESHE has organized "life of project" strategic planning workshops involving regional health bureau, zonal, and woreda staff as well as NGO partners to ensure alignment of its annual work plans and activities with the regional HSDP strategy.

The CHPI is a community mobilization program that uses health promoters selected by their communities to strengthen community based health services by serving as role models and delivering preventive health messages and materials. When CHPI was first rolled out, few HEWs had been recruited, trained and deployed but the HSEP has expanded rapidly in the past three years. ESHE quickly recognized that a formal partnership between CHPIs and HEWs offered a unique opportunity to expand services to rural communities within the framework of HSDP III. ESHE consequently adjusted and refined the CHPI approach to take advantage of this synergy, training HEWs in communications, community mobilization and supervision so they can support and even train CHPIs. The majority of kebeles in ESHE woredas now have HEWs, enabling better coordination and follow-up of CHPs in the community. As well, the GOE has adopted the community health promoter strategy as an element of its health extension program.

ESHE also supports HSDP III priorities under its health care financing component. The Health Care Financing strategy was developed by the FMOH and ratified by the Council of Ministers in 1998. ESHE is working directly with GOE counterparts to realize many of the strategy components, including: development of National Health Accounts: development and application of the legal framework for health care reform; introduction of the Marginal Budgeting for Bottlenecks (MBB) tool, institutionalization of the MBB at national and regional levels, and development of a district-level costing tool; and developing concept and background documents and organizing study tours corresponding to GOE health care financing priorities.

2. Coordination and Relationships with Partners and Stakeholders

The evaluation team gathered an extensive amount of information on the topic of coordination and relationships with partners from observation, context and interviews -- all stakeholder and site visit instruments included one or more specific questions on the nature and quality of coordination and interactions with ESHE staff. Virtually all of the feedback received was quite

positive and many of the specific comments have been summarized or quoted in previous sections of this report. In summary, the evaluators would describe ESHE coordination and working relationships with GOE counterparts at all levels, other donors, international organizations and NGOs as productive, collegial and valued. In two instances, however, the team received feedback indicating that the working relationship was or had been strained. The team has summarized this feedback in a separate memorandum to USAID.

3. Contributions to Strategic Objective Level and Regional Level Results and Impact

ESHE works in 64 districts in Oromia, Amhara and SNNP, with a potential beneficiary target population of 15 million, or nearly 20% of the total national population. The regional-level public health impact potentially attributable to ESHE, however, varies across the three regions owing to population coverage:

Region	Total Population	Population Residing in Focus Woredas	% of Population in Focus Woredas
Oromia	26,000,000	4,500,000	17%
Amhara	19,700,000	4,850,000	25%
SNNP	15,300,000	6,000,000	40%

ESHE's contribution to regional level impact is probably greatest in SNNP where 40% of the population resides in focus woredas; in Oromia, by contrast, where only 17% of the population falls into ESHE-assisted woredas, even if ESHE-assisted woredas outperform the region as a whole, the public health impact for the entire region will not be significant.

In most instances, ESHE woredas have met or exceeded targets for DPT3 and polio3 coverage, vitamin A, immunization dropout, and quarterly supervisory visits (Table 3). In addition to having had a substantial positive impact on utilization of services, products and behaviors in focus woredas, ESHE averages exceed the regional average in all three focus regions for DPT3 coverage.

Table 3: Achievement Vs. Targets in ESHE Focus Woredas July 1, 2005 – June 30, 2006 %				
Amhara Region				
Indicator	**Baseline 2002/2003***	**Year 3 Target**	**Year 3 Achieved****	**Regional Average****
DPT3	63	80	89	74
Polio3	61	70	NDA	NDA
Vitamin A	15	65	88	NDA
DPT1-DPT3 dropout	29	<10	9	NDA
Quarterly supervision	19	50	87	NDA
Oromia Region				
DPT3	35	80	91	69
Polio3	NDA	80	84	NDA
Vitamin A	44	65	99	NDA
DPT1-DPT3 Dropout	29	<10	11	NDA
% Worho's conduct quarterly supervision visit	6	50	83	NDA
SNNP Region				
DPT3	60	80	95	91
Polio3	50	80	94	NDA
Vitamin A	14	80	93	NDA
DPT1-DPT3 Dropout	19	<10	5	NDA
% Worho's conduct quarterly supervision visit	40	50	56	NDA
NDA: No data available				

*Source: ESHE Baseline Survey ** Source: Routine HMIS

There were also substantial increases in Timely Initiation of Breast Feeding (TIBF) and Exclusive Breast Feeding (EBF) in ESHE focus areas where CHPs had been active for at least 6 months:

- Amhara TIBF coverage increased from 23% to 60% and EBF increased from 74% to 81%.
- SNNP TIBF coverage increased from 45% to 50% and EBF from 58% to 64%.
- Oromia TIBF coverage increased from 43% to 77% and EBF from 39% to 63%.

Finally, at the time of the 2003 SNNP survey, less than 1% of households in ESHE woredas had an ITN. The community assessment in 2006 showed 40% of households in malaria infested areas had an ITN. More importantly, 33% of mothers with under-five children and 29% of children under-five slept under the ITN.

4. Appropriateness of ESHE Three Pillar Approach and Community Mobilization Model

The three pillars of the **ESHE Three Pillar Approach** are a) strengthen health worker skills; b) improve health systems; and c) promote positive family and community behaviors. The approach is based on the premise that each of the interventions alone is critical to improving child health and when taken together they are mutually reinforcing, i.e., the sum of the whole is greater than the sum of the parts.

The evaluation team believes that the Three Pillar Approach is both appropriate and effective. In Ethiopia, there is strong recognition that improvements in facility-based services alone cannot contribute significantly to reductions in child mortality. Access to qualified health providers or facilities is limited and many children die at home owing to lack of knowledge or delays in seeking appropriate care. ESHE has worked effectively to simultaneously strengthen health systems, health worker skills and positive community and household health practices. Moreover, the approach is applied across the health sector, from policy at the national level, planning and management at the regional, zonal and woreda levels, to improved practices at the household and community levels. Each health program intervention combines work across the three pillars to achieve impact. The evaluation team believes that this three-pronged approach multiplies community-level impact and that the large gains in use of health products and services are largely attributable to this approach.

As discussed in the Community Mobilization section of this report, the evaluation team believes that much of ESHE's success in improving key health indicators can be attributed to its community mobilization model, the Community Health Promotion Initiative (CHPI). First, the initiative mobilizes communities at the kebele level to raise awareness; next CHPs are selected, trained and challenged to model health behaviors within the community; finally, CHPI links CHPs to the formal network of HEWs.

The CHPI, a community volunteer model, is low-cost by definition and therefore appropriate if resources are limited. The evaluators believe that in the Ethiopian context, a community-level program will be a necessary element of any effort to improve access to quality child health services. The broader question of whether the CHPI is the most feasible and practical community mobilization model for Ethiopia will require further study (see Major Recommendation 7.)

5. ESHE Program Links to Safety Net Program

Seven donors support the GOE safety net program which provides cash transfers and food aid for disaster relief and preparedness. USAID's contribution to this program is primarily food aid channeled through eight international NGOs operating in safety net zones. Each NGO works directly with woreda-level officials to plan and implement safety net resources.

In 2004, USAID/Ethiopia revised its country strategy to address the problem of chronic food insecurity by strengthening emergency preparedness. Recognizing the potential links between community-based health programs and safety net programs, USAID modified the JSI contract to intensify activities within existing safety net areas of ESHE focus regions and woredas. The

contract amendment called for expanding the CHPI and strengthening health systems in these woredas.

50 of the 64 ESHE focus woredas are designated as "safety net" woredas. ESHE trained community nutrition promoters in these woredas and facilitated the creation of woreda-level coordination forums between health and nutrition partners (Government and NGOs, World Bank Food Security Project, Disaster Prevention and Preparedness Office, etc.). The objectives of woreda-level coordination are to: harmonize health and nutrition programs and messages communicated by different organizations and cadres of community workers (health, agriculture, emergency); strengthen community nutrition promotion activities by linking and coordinating various community volunteers through HEWs; strengthen counseling of mothers/caretakers participating in Community Therapeutic Feeding Programs; and introduce essential newborn care messages to community nutrition and health promoters.

Implementation guidance: Forge a closer partnership between ESHE and Safety Net program managers and front-line staff. While training of NGO staff and committees for woreda-level coordination have taken place, the evaluation team saw no evidence of day to day, practical interactions. The woreda and zonal staff interviewed were not always aware of direct links between ESHE and safety net programs. Ultimately the evaluators felt there was potential for more synergy between ESHE and the NGOs responsible for safety net program implementation. For example, public works activities could serve as a channel for sharing health information and materials; and CHPIs and HEWs could refer the parents or caretakers of malnourished children to safety net sites.

6. Replication of ESHE Interventions in non-ESHE Woredas

In a number of cases, ESHE interventions have been replicated in non-ESHE woredas by the GOE, NGOs, international organizations and other donors. These findings are encouraging and indicate that there may be additional opportunities for leveraging additional resources or policy dialogue with the GOE to assume a share of program costs. The Regional Health Bureaus in focus regions have embraced the CHPI initiative. The SNNP RHB has trained CHPs in non-ESHE areas. Several woredas in ESHE regions have trained CHPs using their own funds and/or funds solicited from other donors based on a desire to expand the program more rapidly. In addition, some HEWs have taken the initiative to train CHPs from the kebele budget or their own pockets. NGOs including GOAL, Concern, Save the Children USA and UK have also trained CHPs using the ESHE module and materials.

The Family Health Card is being used as a key promotional tool by UNICEF, the World Bank Food Security Project, Concern, Save the Children USA, and GOAL. UNICEF distributed 1.3 million Immunization Diplomas to non-ESHE areas in ESHE regions. Recognizing the importance of the Immunization Diploma, WHO has expressed interest in printing and distributing it nationwide with vaccine shipments.

ANNEX A: EVALUATION SCOPE OF WORK

Scope of Work
Mid-Term Evaluation
Essential Services for Health in Ethiopia Project
Contract No. 663-C-00-04-00403-00

Purpose

The purpose of this activity is to conduct an evaluation of the Essential Health Services for Health in Ethiopia (ESHE) Project implemented through a contract with John Snow International (JSI). The evaluation, to be conducted by a team of international and local experts, will consist of a comprehensive technical and managerial review of the appropriateness of the approach and results to date. The Project's impact on the improvements of child health and health systems will be a major focus of the evaluation. Findings from the evaluation will shape the direction of future USAID-funded child health services and health systems programs.

Two major program areas will be evaluated: (a) Child Health (b) Health Sector Reform and System Strengthening. These program areas will be reviewed in the context of the project's strategic framework: (1) Strengthen Health Workers Skills (2) Improve Health Systems (3) Improve Community Household Practices.

The evaluation team will include four international experts (three from USAID/W) and eight local experts from the Federal Ministry of Health, Regional Health Bureaus and Ministry of Finance and Economic Development. One international expert will serve as the team leader and be responsible for coordinating the effort and ensuring that the timeline and deliverables are met. Two representatives from USAID/Ethiopia will also be on the team.

The methodology of the evaluation will be through triangulation. Relevant data will be gathered from multiple sources including site visits, interviews and reviews of progress reports, data and national documents. The team will conduct field observation visits across the three regions using qualitative and quantitative data collection methods.

Background

Implementation of the Essential Services for Health in Ethiopia (ESHE) project started in November, 2003. ESHE supports child health activities in 64 selected woredas serving 15 million people in SNNP, Oromia and Amhara, the three most populated regions of Ethiopia. In the Health Sector Reform area, the project works with the FMOH, regional health bureaus and woreda health offices to institute and implement the health sector financing reform to improve financial resources to the sector. At the community level, the project focuses on community mobilization interventions through the Community Health Promotion Initiative (CHP) to engage community members to improve the health status of their family members. The project is USAID's flagship child health and health systems strengthening technical assistance program in Ethiopia.

The technical areas of the Contract are as follows:

1. Child Health

- **Expanded Program on Immunization (EPI**): The project developed a refresher training package for EPI. Decentralized trainings were to be conducted for frontline health workers with regular follow-up and monitoring of EPI plans at the facilities, woreda and regional levels.
- **Essential Nutrition Actions (ENA**): The project promotes key nutrition behaviors that are doable and scientifically proven to improve the nutrition status of children and mother. The project also provides refresher training and technical assistance to the frontline health workers on ENA in the focus woredas.
- **Integrated Management of Childhood Illness (IMCI)**: IMCI is designed as a holistic approach to improve the quality of care by frontline health workers for sick children as well as improve immunization, nutrition counseling and referral during sick child visits. The Project is working with the focus regional health bureaus to improve health services delivery management and to build the capacity of health facility staff to manage cases and create awareness at the community and household levels. The Project supports the promotion of IMCI and provides technical assistance in the revision and implementation of the new version of IMCI referred to as Integrated Management of Newborn and Childhood Illnesses.

2. Behavioral Change and Communication

- ESHE interventions in Behavioral Change Communication address the complex nature of changing behaviors and consequently focus on promoting small doable health practices through "Community Health Promotion Initiative." In addition, the project works through mass media and distribution of print materials to bring behavioral change messages to communities in the three focus regions.

3. Performance Improvement

- **Health Management Information System (HMIS***):* ESHE provides technical assistance and refresher training on HMIS to improve the culture of HMIS data use for decision making in the focus woredas.
- **Supportive supervision:** ESHE provides technical assistance and training to strengthen supportive supervision in the focus woredas. It supports the development of integrated supervisory checklists and their use through strengthening review meetings.

4. Health Care Financing Reform

ESHE supports the implementation of the Health Care Financing Strategy adopted in 1998 to bring structural changes in the Ethiopian health sector. The Health Care Financing Reform package includes:

- Authorization of health facilities to retain revenues generated in their facilities
- Revision of fees
- Decentralization of the management of health facilities to Health Management board
- Authorization to outsource non-clinical activities
- Improving the waiver system and exemptions
- Initiating health insurance schemes

The Health Care Financing Reform is national in scope with additional support for the implementation of the reform in the three focus regions.

Key Information about the JSI/ESHE Contract Agreement

- **No. 663-C-00-04-00403-00.** This is a five-year agreement which began November, 2003 and continues through November, 2008.
- Total Value: $22, 758,287
- Geographic Coverage: For child health, 64 woredas in SNNP, Oromia and Amhara regions. Health Care Financing Reform activities are supported at the Federal level with support for implementation in the three focus regions.

Objectives of the Evaluation

1. To assess the contributions JSI/ESHE has made to child health and health systems improvement in the focus woredas, regions and at the national level.
2. To assess ESHE cornerstone strengths and innovative activities and determine those that should be continued and emphasized in follow-on activities.
3. To evaluate ESHE's approach in the context of the Host Government's Health Services Extension Program and Health Sector Development Program priorities.
4. To assess ESHE's collaborative and coordination efforts with USAID partners, host government and other stakeholders.
5. To present recommendations for future ESHE programming.
6. To present recommendations for future USAID support for maternal, newborn and child health programming and health sector reform/finance.

Questions

The evaluation will seek to answer the following questions:

1. Does the project support USAID SO 14 and intermediate results? Does the project contribute to USAID indicators? If so, discuss the indicators and targets and achievement (or lack of) against those.
2. Does the project support the MOH Health Sector Development Plan (HSDP) and the Health Services Extension Program (HSEP)? Discuss.
3. What are the notable achievements of the ESHE project to date?
4. Is the project on track to meet stated LOP goals and objectives?
5. Is the ESHE Three Pillars strategy appropriate and effective?
6. Are the technical areas and current approach appropriate now and for follow-on programming? What are the gaps, if any?
7. A decision was made during the ESHE project design phase to work in three regions in a total of 64 woredas. Does this design lead to public health impact at the regional level? Are project interventions adequate for improving child health and health systems?
8. Is the geographic alignment with the Safety Net woredas appropriate and effective? Have program linkages been made with Safety Net activities?
9. With limited resources, what are other feasible and practical models to support access and quality of child health services and health systems strengthening?
10. Would it be more effective to have a future program that separates service delivery and systems strengthening, particularly health sector reform?

11. Has the project succeeded in building the technical and management capacity of regional health bureaus, woreda health offices and communities?
12. What is the nature and quality of the relationships between the ESHE project and its local partners, including host government partners at all levels?
13. Are ESHE project initiatives being used by the regions in non-ESHE focus woredas?
14. Is the CHPI a practical approach for the regions to duplicate and scale up without future USAID support?
15. What recommendations does the team have for strengthening the ESHE project?

Evaluation Team

1. **Team Leader—International Consultant.** The Team Leader will be an international consultant with extensive experience in leading evaluation teams and coordinating major program evaluations in child health and health systems. S/he will agree to fulfill his/her responsibilities in two months, spending three weeks in country, and will play a central role in guiding the evaluation process. The consultant will hold conference calls with USAID/Ethiopia representatives before and after the visit to Ethiopia, and will produce a draft followed by a final report for USAID/Ethiopia.

2. **Nutrition and Child Health Expert—USAID/W**. The Child Health Expert will have extensive experience in the provision of routine immunization programs, Essential Nutrition Actions (ENA), Integrated Management of Childhood Illness (IMCI) in a sustainable manner. Experience in Africa is preferable. The advisor will be responsible for writing some sections of the child health section of the report.

3. **Community Health Expert—USAID/W.** S/he will have extensive knowledge in community mobilization to promote behavioral change for improved family health. Experience and knowledge in promoting community health in resource-poor settings is essential. The advisor will be responsible for writing some sections of the report.

4. **Health Care Financing Expert—USAID/W.** S/he will have extensive knowledge of Health Care Financing Reform implementation, including fee retention, fee revision, outsourcing, decentralization, waiver, exemption, health insurance, etc. Strong background and experience in resource poor countries is essential. The advisor will be responsible for writing some sections of the report.

5. **Local Coordinating Consultant.** The local consultant will be responsible for logistics, coordination and administrative support, and ensuring all aspects of the evaluation are carried out seamlessly. S/he will assist the Team Leader in facilitating meetings, coordinating logistics and organizing site visits. The consultant will collect and disseminate background documentation to the evaluation team, and assist in the development of a qualitative instrument to be used during site visits.

6. **Eight Representatives from the Government of Ethiopia.** Partners from the Federal Ministry of Health (1), Ministry of Finance and Economic Development (1) and Regional

Health Bureaus (2 per Bureau) will participate in the evaluation. The local experts will have expertise in one of the focal areas and be experienced in conducting evaluations.

7. **Two USAID/Ethiopia staff.** One member of the Health Team and a second USAID/Ethiopia representative (to be selected) will join the evaluation team and provide technical support as necessary.

   USAID will hire the international and local consultants, and cover the costs of hotel, travel and per diem for Government of Ethiopia staff participating in the evaluation.

Evaluation Process

1. Conduct in-country meetings with USAID/E and government representatives.
2. Hold meetings with ESHE/JSI staff and their sub-contractors and conduct selected interviews.
3. Review performance data from ESHE and sub-contractors by program areas.
4. Conduct field visits to selected woredas of the three regions (the teams will split-up in order to accomplish this task). It is anticipated that each team will be in the field 10 days. Team members will first convene in Addis Ababa before forming sub-teams for site visits to SNNPR, Oromia and Amhara.
5. Interview government officials at all levels, members of the community, community health promoters, health extension workers, frontline health workers, etc.
6. Hold discussions among the evaluation team to review information and data collected.
7. Review ESHE reports, baseline assessment reports, DHS 2005, etc
8. Write evaluation report and provide recommendations.

Time Frame

1. The evaluation will take place over one month and require most of the team members to spend three weeks in-country.

2. During the week of November 20, 2006, the Team Leader, with the assistance of the Local Coordinating Consultant, will convene conference calls with USAID/E, the evaluation team and to a limited extent with ESHE to review technical documents (some can be sent electronically), review site visit methodology and instruments to be implemented, develop the format for the reports, and prepare the teams for in-country activities.

3. Team members will commence their activities in Addis Ababa on November 27, 2006 with a 2-day introductory and planning meeting.

4. Interviews with key counterparts in Addis Ababa will begin on Wednesday, 29 November.

5. Five days of field visits will begin December 3, 2006 (returning to Addis on 8 December). Government of Ethiopia representatives will be expected to participate on the field visits. The team will be divided into three sub-teams for the field trips and each team will be assigned to a program region.

6. The entire evaluation team will spend 9 December compiling findings from the field visits and discussing recommendations.

7. From 11 – 15 the Team Leader and other team members will develop the first draft of the document for submission to USAID by COB on 14 December. A debriefing will be held with the Team Leader and mission representatives on Friday, 15 December.

8. USAID will provide written comments on the report to the Team Leader by 22 December. USAID/Ethiopia will allow fifteen (15) days for the Team Leader to produce a final evaluation report. The report will be submitted no later than 12 January 2007.

Specifics of the Contract with the Local Consultant

- A six-day work week is authorized.
- All associated travel and per diem costs will be covered under the contract with USAID/E.
- Work is to begin in-country October 15, 2006 and terminate December 15, 2006.
- Additional work time will be required for reviewing materials, participating in conference calls (all team members), and finalizing the report (team leader).

ANNEX B: ORGANIZATIONS AND INDIVIDUALS INTERVIEWED

STAKEHOLDERS IN ADDIS:

Federal Ministry of Health

Dr. Nejimudin	Head, Planning and Programming
Ato. Wondewosen Temiess	Head, Health Extension and Ed.
Ato Yohannes	Training Department
Dr. Tesfaynesh	Head of Family Health Department

UNICEF

Vivianne Van Steirteghem	Health Section Head

World Health Organization

Dr. Asnekaw	EPI

World Bank

Dr. Gebre Selaisse

Health Communication Partnership

Elsa Gebresadik	Country Director

DELIVER

Mr. Bernard Fabre	Chief of Party

RPM Plus

Ato. Nigussu Mekonnen	Chief of Party

Pathfinder

Ato. Tilahun	Country Director

AMHARA:

Amhara Regional Health Bureau

Tilahun Yimaledu	Acting RHB Head
Sr. Zufan Abera	Acting Head Health Programming Department
Tesfa Deresse	Head Plan and Programming Department
Mulusau Ligalem	Pharmaceutical Procurement and Drug Supply

ESHE Amhara

Dr. Tadele Bogale	Regional Project Manager
Worku Berhe	Woreda Coordinator – South Gondar
Zelalem Abera	Field Officer – South Gondar
Walelign Meheletu	Performance Improvement Specialist
Kassaw Woldie	Health Care Financing Improvement Officer
Genet Anteneh	HCF Specialist
Mulu Hailu	Field Officer – West Gojam
Betemariam Alemu	CHP Specialist
Selamawit Teshome	Nutrition Specialist
Bizuhan Gelaw	Child Survival Specialist

Amhara President Office
Merhatsidik Mekonnen Legal Advisor to Regional President

Jiba Tehnan Woreda Health Office
Ayenah TirunehSurveillance and Diagnostic Expert
Kebede Tafara Malaria and Disease Control
Hamara Belay Health Program Team Coordinator
Haptu Sisay Environmental and Sanitation Extension Worker
Sr. Yeniwerk Acham Health Service Organization and Management

Shemebed Woketa Community
2 Health Extension Workers
1 Front line Health Worker from Health Post
8 Community Health Promoters (7 men and one woman)

Jiga Health Center
Tewodros Getahun Head of Health Center
Deras Aschalau Clinical Nurse
Enago Belay Sanitary and Environmental Technician

Dera Woreda
Worku Kinde Acting Head and Health Program Desk
Abebebau Basazinaw Health Service and Training Coordinator

Shemede Weketo - Model Kebele
Tigist Abalu Health Extension Worker
Abebu Seyoum Health Extension Worker
NA Kebele Chairman
NA Police Officer

Woreta Health Center
Demeka Meleda Head of Health Center – Nurse

Aura Amba Community
Himanawt Health Extension Worker
NA 2 Community Health Promoters
Zumura Nuru Head of Community
NA Public Relations Officer for Community

Merawi Woreda
Yibeltal Berie Health Extension Coordinator and Acting WorHO Head

OROMIA:

Oromia Regional Health Bureau
Dr. Zenebech Deputy Head of Health Bureau
Ato. Asefau Planning and Programming Department Head

ESHE East Hararghe
Kebebew Aberra District Coordinator
Sr. Gelay Hassen Field Officer

Zonal Health Department Head
Dr. Abelurhamen Zonal Health Department Head
Almayeh Keberkum Planning and Training Expert

Chelenko Health Center
Mulugeta Demessie MCH Expert and Woreda Delegate

Liliftu Health Post
Addis Asfaw Health Extension Worker
Abedu Hassan Community Health Promoter

ESHE West Hararghe
Dedefu Teno Woreda Coordinator
Taye Girma Field Officer

West Hararghe Zonal Health Department
Abdie Beikir Health Program Team Leader

Yebido Shenbeko Health Post
Mefthua Nur Health Extension Worker

Gemechis Woreda Health Office
Kitila Buta Health Office Delegate
Makeda Umer Community Health Promoter
Gosa Lule Community Health Promoter

Kuni Health Center
Sr. Kalkidan Dejene MCH Nurse

Kuni Segeria Kebele
Getahun Deselagne Kebele Chairperson
Omer Muhamed Alyu Farmer
Tiru Ibiru Housewife
Kememoa Zegeye Housewife

ESHE Cluster Office – East Shewa Zone
Getachew Gebre ESHE Staff

SNNPR:

SNNPR Regional Health Bureau
Dr. Shiferaw T/Mariam RHB Head
Kare Chawicha Deputy RHB Head
Dr. Sahle Sita Family Health Department Head
Dr. Efrem Teferi Child Health Team Leader
Dr. Alemayehu Belayneh Planning and Programming Dept. Head
Ato. Getachew Health Extension Program

ESHE/SNNPR office Awassa
Dr. Hailemariam Legesse Regional Project Manager

Awassa City Administration Health Office
Ato. Begashaw Head of Health Office

Awassa Health Center
Amsalu Girma Head of Health Center

Dawro Woreda
NA Health Center Staff
Abate Albe Woreda Office Head

Sidama Field Visit
Million Fissehaye ESHE Sidama Woreda Coordinator

Sidama Zonal Health Office
Ato Elias Sidama Zonal Health Dept. Head

Wondo Genet Woreda Health Office
Ato. Yohannes Letamo WorHO Head 091 682 5481
NA Community Health Promoters
NA Health Extension Workers

Badewacho Woreda Health Office
Ferew Selomon WorHO Head

Shone Kobeb Kebele
Ato. Berhanu Ejie, Kokeb Kebele activities

Bolosso Sore
Ato. Kako WorHO Head
Ato. Bergene Health Service and Training Team Leader
NA Community Health Promoters
NA Health Extension Workers
Abebe Fola ESHE Team
Asrat Gebeyehu ESHE Team

ANNEX C: BIBLIOGRAPHY

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ANNEX D: STAKEHOLDER AND FIELD VISIT ITINERARY

Essential Services for Health in Ethiopia (ESHE)
Itinerary for Mid-Term Evaluation 2006

Thursday, November 30, 2006

Time	*Event*	
	Team 1 Carol Dr. Aregawi Bassamo Hailu Yogesh	**Team 2** Dr. Aberra Amsalu Maria Rachel
9:00	FMOH Dr. Nejimudin Head, Planning and Programming 011 553 5938	UNICEF Viviane Van Steirteghem Health Section Head 011 551 5155
10:00	Motorpool pick-up at World Bank	Motorpool pick up UNICEF
10:30	World Bank Dr. Gebre Selaisse	Motorpool drops Maria at World Bank – team 2 continues to HCP
10:45	A **third** vehicle picks up Carol for transport to USAID For 11:00 mtg with Susan	
11:00		HCP Elsa Gebresadik Country Director 0916 822 911
11:30	Motorpool pick up at World Bank to USAID	
12:00		Motorpool pick up at HCP to USAID mission
	LUNCH BREAK	LUNCH BREAK
13:00		Motopool USAID to FMOH
14:00	Motorpool pick up at USAID to FMOH	

14:30	FMOH Ato. Wondewosen Temiess Head, Health Extension and Ed. 011 551 829	
15:30	Motorpool pick up at FMOH to DELIVER	FMOH Ato Yohannes Training Department
16:00	DELIVER Mr. Bernard Fabre	
16:30		
17:15-18:30	**ALL TEAM MEMBERS** Recap session at Hilton Hotel Venue: Meet in front of Reception Topic: Consolidate key findings from stakeholder interviews	

Friday, December 1, 2006

Time	***Event***

Team Oromia:

Rachel
Amsalu
Bassamo

9:00-10:00	**Oromia sub-group (Rahcel, Basamo, Amsalu) meet with Oromia RHB in Addis**
10:00-12:00	Oromia Evaluation Team sub-group meet with ESHE Oromia staff (location tbd)

Stakeholder Team

Carol
Dr. Aberra
Dr. Aregawi
Hailu
Maria
Yogesh

9:00-10:00	RPM Plus – Ato. Nigussu Mekonnen 0911 226 909
10:30-11:30	WHO TBD

12:00-13:30	Lunch Break
13:30-14:30	**Venue: Hilton Conference Room** **Topic:** consolidate findings from ESHE and key stakeholder meetings
14:30-15:00	Develop site visit instrument
15:00-15:15	Coffee Break
15:15-17:00	Develop site visit instrument

Saturday, December 2, 2006

8:30-12:00	**Venue:** Hilton Conference Room **Topic:** Finalize and copy site visit instruments
Am	Motorpool vehicles departs Addis for Bahir Dar and Dire Dawa

Divide into three teams for field visits

Sunday, December 3, 2006

Time	*Event*
AM	Check-out of Hilton Hotel
TBD	Motorpool meets Amhara Team at Hilton for transport to airport
7:20	Flight to Bahir Dar departs Addis
8:00	Met at Bahir Dar airport by USAID motorpool for transport to hotel Overnight at Summerland hotel, Bahir Dar Four rooms reserved: ETB 93.00 for Ethiopian and 237.00 for foreigners Contact: Ato. Mengist Ayew 091 876 9056
TBD	Motorpool meets Oromia Team at Hilton for transport to airport
7:00	Flight to Dire Dawa departs Addis
8:00	Met at Dire Dawa airport by USAID motorpool for transport to hotel Overnight at Ras Hotel, Harar Four rooms reserved: 62.50 for Ethiopian 162.50 for foreigners Contact: Ato. Yeshitila 025 666 0027
12:00	Motorpool meets SNNPR Team at Hilton hotel for drive to Awassa **NOTE: SNNPR Team will meet with Dr. Shiferaw, SNNPR upon arrival in Awassa** Overnight at Gebre Kristos Hotel, Awassa 3 rooms reserved; ETB 130.00 for Ethiopian and ETB 160.00 for foreigners Contact: Wzo. Tesfanesh 046 220 2780

Team 1: SNNPR
Maria Francisco
Yogesh Rajkotia
Tilahun Yimaledu

Monday, December 4, 2006

Time	*Event*
9:00-12:00	Meeting with SNNPR Regional Health Bureau Head Dr. Shiferaw, T/Mariam RHB Head 091 123 7530 Ato. Kare Chawicha, Deputy Head 091 658 0425 Ato. Basamo Deka, Health Service and Training Dept. Head 091 135 7002 Dr. Sahle Sita, Family Health Department Head, 091 176 8208 Dr. Efrem Teferi, Child Health Team Leader 046 220 5950 Dr. Alemayehu Belayneh, Planning and Programming Dept. Head 046 220 7073 Ato. Getachew, Health Extension Program Topics to include: Proclamation and Implementation of Health Sector Finance
12:00-13:30	Lunch Break
13:30-17:00	Meeting with ESHE/SNNPR office Awassa Dr. Hailemariam Legesse, Regional Project Manager 091 682 8156 or 046 221 0763
18:00	Overnight at Gebre Kristos Hotel, Awassa

Tuesday, December 5, 2006

Time	*Event*
9:00	Awassa City Administration Health Office (Ato. Begashaw) 046 220 6055 Health Center Awassa – Health Care Financing (Amsalu Girma) 091 185 3487
12:00	Lunch Break
14:00	Sidama Field Visit – Million Fissehaye, ESHE Sidama Woreda Coordinator 091 167 4008
14:15	Sidama Zonal Health Office, Ato Elias, Sidama Zonal Health Dept. Head (091 682 4791)
15:30	Wondo Genet Woreda Health Office Ato. Yohannes Letamo, WorHO Head 091 682 5481 Meeting with Community Health Promoter and Health Extension Worker
17:00	Depart for Awassa
18:00	Overnight at Gebre Kristos hotel, Awassa

Wednesday, December 6, 2006

Time	*Event*
8:00	Check-out of Gebre Kristos Hotel, Awassa and depart for Shone

9:30	Badewacho Woreda Health Office – Ferew Selomon, WorHO Head, Ato. Berhanu Ejie, 091 131 5138 Shone, Kokeb Kebele activities
13:00	Lunch (Shone or Sodo)
14:00	Depart for Bolosso Sore
15:00	Bolosso Sore Field Visit Ato. Kako, WorHO Head 091 199 5575 Ato. Bergene, Health Service and Training Team Leader 046 55 2344 Meeting with Community Health Promoter and Health Extension Worker ESHE Team: Abebe Fola, 091 176 3308, Asrat Gebeyehu 091 137 2621
17:30	Depart Bolosso Sore for Sodo
18:00	Overnight Bekele Molla, Sodo 3 rooms confirmed: ETB 66.00 for Ethiopians/ ETB86.00 for foreigners Contact. Ato. Belete 046 551 2382

Thursday, December 7, 2006

Time	*Event*
8:00/9:00	Bolosso Sore meetings continued
12:00	Lunch Sodo
12:30	Depart for Addis Ababa
18:00	Arrive Hilton Hotel for overnight in Addis

Team 2: Amhara
Carol Flavell
Hailu Kassa
Dr. Aregawi Aklilu

Monday, December 4, 2006

Time	*Event*
9:00	Meeting at Amhara Regional Health Bureau
9:00	Dr. Asrat Genet, Head RHB
10:00	Sr. Zufan Abera, Acting Head of Health Programming Department
11:00	Ato. Merhatsidik Mekonnen, Advisor to Regional President
12:00	Lunch
13:00	Meeting at ESHE/Amhara offices (Dr. Tadele 058 222 1140)
18:00	Overnight at Summerland Hotel, Bahir Dar

Tuesday, December 5, 2006

Time	*Event*
7:30	Depart Hotel for Finote Selam (180km from Bahir Dar)
10:00	Jabi Tehnan Woreda Health Office (Ato Simeneh Worku, Head) – visit Jiga Health Center (Ato Tewodros, Head) and Shemebed Woketo Health Post
12:00	Lunch at Finote Selam Town
14:30	Visit Jiba Health Center (Ato. Tewodros, Head) and Shemebed Woketo Health Post

18:00	Overnight at Summerland Hotel, Bahir Dar

Wednesday, December 6, 2006

Time	*Event*
8:00	Depart hotel for Ambesamie town (50 km from Bahir Dar)
9:30	Dera Woreda (Model Kebele, Woreda Health Office)
12:00	Lunch
13:30	Fogera Woreda Health Office, Woreta Health Center (HCF)
15:00	Visit Aura Amba Community
15:00	Kebele Health Office
18:00	Overnight at Summerland Hotel, Bahir Dar

Thursday, December 7, 2006

Time	*Event*
7:30	Depart Hotel for Mecha Woreday in Merawi town (Ato Kebre Kidan Gebre Mariam, Woreda Health Office Head) – visit Merawi Health Center (Ato. Mebratu Entehabu, Head) – meet with staff trained in EPI and ENA, meet with CHPs and HEWs
12:00	Lunch
13:20	Ethiopian flight 123 departs Bahir Dar
14:20	Ethiopian flight 123 arrives in Addis – team met by USAID motorpool for transport to Hilton

Team 3: Oromia
Rachel Kearl
Basamo Deka
Amsalu Shiferaw

Monday, December 4, 2006

Time	*Event*
8:30	Depart Ras Hotel, Harar
9:00	East Hararghe ESHE Team (Kibebew Abera 091 574 5603) or Sr. Gelaye 0911 726004) Zonal Health Office (Dr. Abdurhaman 0915330067) Harar
11:00	Metta Woreda Health Office (70 km from Harar) (Ato Ahmedin 091 574 5677)
12:30	Lunch (Cheleneko)
2:00	Chelenko Health Center, near Metta Woreda Health Office (Ato. Mulugeta) Field Visit to see Health Extension Workers and Community Health Promoters (Duddeala village near Chelenko HC)
18:00	Overnight in Chiro, Burka Hotel (022 551 0208)

Tuesday, December 5, 2006

Time	*Event*

9:00	West Hararghe ESHE Team (Dedefo Teno 0916821962) or (Taye 0915751992)
	West Harage ZHO Head (Ato Sufian 091 573 3330), Chiro
10:30	Yabedo Shenbeko Health Post (9km from Chiro) (HEW-Muftha) and village meetings with Health Extension Workers and Community Health Promoters
12:30	Lunch Chiro
14:00	Gemechis Woreda Health Office (17km from Chiro) (Ato Abdella 091 1761 198)
	Kuni Health Center (Sr. Kalkidan 091 136 6721)
18:00	Overnight in Chiro at Burka hotel

Wednesday, December 6, 2006

Time	***Event***
8:00	Depart for 2.5 hour drive to Adama (stop at Awash Park)
12:00	Lunch (Adama)
	Meet with East Shoa ESHE team (Ato Teshome 0911422734) or Getachew (0911 746398)
13:30	Zonal Health Office, Adama (Ato Direba 0911 840123)
18:00	Overnight in Adama (Nazreth) at Safari Lodge
	Four rooms reserved: ETB 281
	Contact: Ato. Derege 022 112 2011

Thursday, December 7, 2006

Time	***Event***
8:00	Depart for Debre Zeit
10:30	Gimbi Woreda Health Office (30 km off Addis Road) (Ato. Zerihun 022 451 0102)
	Chefedonsa Health Center, meeting with CHPs and HEW in Kersa near Chefedonsa
14:00	Lunch Debre Zeit
15:00	Depart for Addis
16:30	Arrive to Addis – check in Hilton

ANNEX E: GUIDANCE FOR STAKEHOLDER INTERVIEWS

GUIDANCE FOR STAKEHOLDER INTERVIEWS

(This document is intended to provide general guidance for stakeholder interviews and should be adapted and expanded to reflect the persons or organizations being interviewed. The interview team will discuss, reach consensus and record major observations, comments and quotes following the interview.)

Team lead thanks the stakeholder for taking the time to meet with the team and introduces team members, then briefly describes the purpose and timeframe for the ESHE evaluation.

Sample questions follow:

We are interested in hearing the observations and impressions that you and your staff have of the ESHE program. First, could you tell us about your experience working with the ESHE project and its staff?

Has collaboration with ESHE had a direct impact on the programs or staff you manage or supervise? Please describe or cite examples?

Have your interactions and work with ESHE met, exceeded or fallen short of your expectations? Please elaborate?

Please describe the degree to which you have been satisfied with the following:
- quality of expertise or support provided by ESHE.
- Responsiveness of ESHE to your needs and priorities.
- Working relationships with ESHE staff.

Are there any EHSE activities or approaches that you find particularly useful or successful or ones you would like to see expanded or replicated.

In your opinion, are there any gaps in the ESHE strategy that should be addressed? If so, please elaborate.

Are there any emerging opportunities or new activities that would benefit from ESHE collaboration?

Do you have any recommendations for strengthening the ESHE program?

Do you have any recommendations for improving future collaboration with ESHE?

Are there any resources or documents that you would recommend to our evaluation team?

Do you have any questions for the evaluation team?

For senior level GOH Officials explore the following:

Does the ESHE Project support your priorities under the Health Sector Development Plan and the Health Services Extension Program? Please elaborate.

What are your views of the Community Health Promotion Initiative? Could it be duplicated in other regions without additional USAID support?

Has ESHE succeeded in building the technical and management capabilities of regional health bureaus, woreda health offices, health posts and communities?

In your opinion, what are the pros and cons of integrating service delivery and health sector reform interventions under the same project?

ANNEX F: FIELD DATA COLLECTION INSTRUMENTS (REGIONAL, WOREDA, HEALTH CENTER/HEALTH POST)

Data Collection Instrument – WOREDA

General

1. How has working with ESHE impacted:
    a. Capacity building (staff)
    b. Responsibilities as defined by HSDP III
    c. Specific program activities, i.e. CHPI, FHC, MCH, HS reform
2. Have you been satisfied with the quality of ESHE's work? Response? Timeliness? Working relationships?
3. Are there any gaps in assistance?
4. What emerging opportunities or priorities do you anticipate, now or in the future?
5. Would you assume responsibility for a given (any) component of ESHE? (i.e., add a line item into your budget for XXX intervention?)
6. Is it possible to replicate ESHE components in new areas on your own?

Special Pharmacies

1. What is the stock situation at facility level?
2. How drugs are being selected? (i.e. selection criteria)
3. In your opinion, are special pharmacies managed well, providing critical drugs and enhancing the health system overall?
4. How is the revenue generated in special pharmacies being used? (efficiency, mismanagement of funds, good governance)
5. Does additional revenue have an impact on drug shortages?
6. Are guidelines in place to manage revenue?
7. **Ask to see a budget (i.e. operating costs).**

User Fee Retention

1. How far along in developing User Fee: (a) Regulations, (b) Directives? What about implementing? If a long timeline, then why?
2. How informed are facilities of User Fee Proclamation?
3. Are user fee guidelines in place? If yes, has quality of services improved?
4. Are management committees operating? What is the composition? How? With what impact?
5. Does a separate account exist for fees? How is it operating?
6. Do you think that quality is sufficient to raise fees?
    a. If not, why not?
    b. What would it take?
    c. How much additional funds do you need to improve quality?
7. **On average, what is the health center budget for recurring/operating costs? (excluding salaries)**
8. **How much on average does health facility generate/year in user fees?**

Waivers/Exemptions

1. Do you think most people getting waivers deserve to be getting one?
2. When does the facility plan on revising fees?
3. Conduct a spot check.

HMIS

1. Do computers exist?
2. Does HMIS Committee exist? If so, how frequently does it meet and what they review?
3. Does HMIS committee link with user fee retention committee?
4. Do data collection guidelines exist?
5. What incentives do health workers receive for collecting and reporting data? Do they feel that it's important?
6. Do data collectors/managers get feedback on data?
7. Is there a point person for gathering/managing data?
8. How do you use the data collected? Does it impact budgeting?
9. How do you ensure that quality data is collected?
    a. **Ask to see guidelines.**
    b. **Ask to see a completed official data collection form (with data collected from HMIS).**
    c. **Has your staff been trained? Are they using what they learned?**
10. What encourages health workers to collect and report quality data? Do they feel that it's important?
11. Do you give feedback to lower levels on data collection and management?
12. Is there a point person for compiling/analyzing data?
13. Is data analyzed and fed to BOFED?
14. How do you use the data collected?
15. Does it impact budgeting?

Outsourcing

1. Does outsourcing exist in your region?
2. If yes, what has been your experience with it?

Standards of Performance

1. Do standards of performance exist regarding:
    a. Service delivery protocols (IMNCI, ENA, EPI)
    b. Management standards
    c. **Ask to see the document(s).**
2. Do you measure performance of health facilities against standards? If so, how often? Do you measure it against the official performance standards?

Supportive Supervision

Supervisor (DISTRICT)

1. Do you have the Integrated Supervisory Checklist? If so, do you use it? Why or why not?
2. Do you have the skills to adequately supervise?
3. Is there a schedule and budget for supervision?
4. To what extent are you able to carry out supervision as planned?

Staff (HEALTH CENTER)

1. Does the Integrated Supervisory Checklist exist? Why or why not?
2. Did the supervision feel "supportive"?
3. Was there a discussion of performance?
4. Did you get written feedback?
5. Was there a plan follow-up. What is preventing you from achieving your plan? If not realizing plan, are there clinical implications?
6. Ask to see a personnel file. Look at IMCI component to gauge clinical performance.

Behavior Change Communication

1. Which of ESHE health communications do you think are most effective at changing behavior? Why do you think this?
2. Should ESHE consider other types of BCC channels (i.e. rural drug vendors, other types of professionals, other forums)?
3. How has the Immunization Diploma impacted the immunization rates?
4. What is the default rate in immunization for kids with cards versus no cards?
5. How is the Family Medical Card used in homes?

Community Health Promoter Initiative

1. How many Community Health Promoters (CHPs) are in your region?
    a. Describe their activities.
    b. Are there other community based workers working in your region focused on other health issues?
    c. Would you like a multi-purpose CHP?
2. Do you know of other similar community-based child health educators (i.e. UNICEF's community-IMCI)?
3. Has the CHPI had an impact? If so, in what way (i.e. improved use of services and health practices in the home)?
4. Would your communities continue to sustain CHPs if ESHE were to go away?
5. Is the CHP critical for the Health Service Extension Program (HSEP) success?
6. Has the training enabled HEWs to mobilize CHPs to make change in health behaviors?
7. Are incentives sufficient to motivate CHPs?
8. How do you handle attrition?

Kokeb/Model Kebeles Initiative

1. What health problems have the Initiative solved?
2. Could this Initiative be replicated in other Kebeles on their own?
3. What lessons have you learned about community mobilization and empowerment as a result of participating in the Initiative?

Coordination

1. How do you coordinate the various NGOs and partners working in Child Survival (i.e. NGO Forum)? Are they working well?

Safety Net?

1. Has ESHE made linkages with Safety Net programs? Is so, where and how?

Data Collection Instrument – HEALTH CENTER/ POST

General

7. How has working with ESHE impacted:
    a. Capacity building (staff)
    b. Responsibilities as defined by HSDP III
    c. Specific program activities, i.e. CHPI, FHC, MCH, HS reform
8. Have you been satisfied with the quality of ESHE's work? Response? Timeliness? Working relationships?
9. Are there any gaps in assistance?
10. What emerging opportunities or priorities do you anticipate, now or in the future?
11. Would you assume responsibility for a given (any) component of ESHE? (i.e., add a line item into your budget for XXX intervention?)
12. Is it possible to replicate ESHE components in new areas on your own?

Special Pharmacies (<u>Heath Center only</u>)

8. What is the stock situation at facility level?
9. How drugs are being selected? (i.e. selection criteria)
10. In your opinion, are special pharmacies managed well, providing critical drugs and enhancing the health system overall?
11. How is the revenue generated in special pharmacies being used? (efficiency, mismanagement of funds, good governance)
12. Does additional revenue have an impact on drug shortages?
13. Are guidelines in place to manage revenue?
14. **Ask to see a budget (i.e. operating costs).**

User Fee Retention (<u>Heath Center only</u>)

9. How far along in developing User Fee: (a) Regulations, (b) Directives? What about implementing? If a long timeline, then why?
10. How informed are facilities of User Fee Proclamation?
11. Are user fee guidelines in place? If yes, has quality of services improved?
12. Are management committees operating? What is the composition? How? With what impact?
13. Does a separate account exist for fees? How is it operating?
14. Do you think that quality is sufficient to raise fees?
    a. If not, why not?
    b. What would it take?
    c. How much additional funds do you need to improve quality?
15. **On average, what is the health center budget for recurring/operating costs? (excluding salaries)**
16. **How much on average does health facility generate/year in user fees?**

Waivers/Exemptions (<u>Heath Center only</u>)

4. Do you think most people getting waivers deserve to be getting one?
5. When does the facility plan on revising fees?
6. Conduct a spot check.

HMIS

16. Do computers exist?
17. Does HMIS Committee exist? If so, how frequently does it meet and what they review?
18. Does HMIS committee link with user fee retention committee?

19. Do data collection guidelines exist?
20. What incentives do health workers receive for collecting and reporting data? Do they feel that it's important?
21. Do data collectors/managers get feedback on data?
22. Is there a point person for gathering/managing data?
23. How do you use the data collected? Does it impact budgeting?
24. How do you ensure that quality data is collected?
    a. **Ask to see guidelines.**
    b. **Ask to see a completed official data collection form (with data collected from HMIS).**
    c. **Has your staff been trained? Are they using what they learned?**
25. What encourages health workers to collect and report quality data? Do they feel that it's important?
26. Do you give feedback to lower levels on data collection and management?
27. Is there a point person for compiling/analyzing data?
28. Is data analyzed and fed to BOFED?
29. How do you use the data collected?
30. Does it impact budgeting?

Standards of Performance

3. Do standards of performance exist regarding:
    a. Service delivery protocols (IMNCI, ENA, EPI)
    b. Management standards
    c. **Ask to see the document(s).**
4. Do you measure performance of health facilities against standards? If so, how often? Do you measure it against the official performance standards?

Supportive Supervision

Supervisor

1. Do you have the Integrated Supervisory Checklist? If so, do you use it? Why or why not?
2. Do you have the skills to adequately supervise?
3. Is there a schedule and budget for supervision?
4. To what extent are you able to carry out supervision as planned?

Staff

7. Does the Integrated Supervisory Checklist exist? Why or why not?
8. Did the supervision feel "supportive"?
9. Was there a discussion of performance?
10. Did you get written feedback?
11. Was there a plan follow-up. What is preventing you from achieving your plan? If not realizing plan, are there clinical implications?
12. Ask to see a personnel file. Look at IMCI component to gauge clinical performance.

Behavior Change Communication

6. Which of ESHE health communications do you think are most effective at changing behavior? Why do you think this?
7. Should ESHE consider other types of BCC channels (i.e. rural drug vendors, other types of professionals, other forums)?

8. How has the Immunization Diploma impacted the immunization rates?
9. What is the default rate in immunization for kids with cards versus no cards?
10. How is the Family Medical Card used in homes?

Community Health Promoter Initiative

9. How many Community Health Promoters (CHPs) are in your region?
    a. Describe their activities.
    b. Are there other community based workers working in your region focused on other health issues?
    c. Would you like a multi-purpose CHP?
10. Do you know of other similar community-based child health educators (i.e. UNICEF's community-IMCI)?
11. Has the CHPI had an impact? If so, in what way (i.e. improved use of services and health practices in the home)?
12. Would your communities continue to sustain CHPs if ESHE were to go away?
13. Is the CHP critical for the Health Service Extension Program (HSEP) success?
14. Has the training enabled HEWs to mobilize CHPs to make change in health behaviors?
15. Are incentives sufficient to motivate CHPs?
16. How do you handle attrition?

HC and HP/HEW:

Background info. No. of staff/sills/training, caseload etc., presence of management and clinical standards, stock outs i.e. coartem and cotrimoxazole?

Health Extension Worker

Technical

1. Are you able to use IMCI or IMNCI for every child <5 in your facility? Why or why not? Look at supervisory checklist to check for performance problems and how they are being addressed.
2. On average, how many referrals are made every month for severely ill children? Mainly for what conditions? (pneumonia, malaria, diarrhea)
3. How do you know they actually went for referral? Do you follow up referral to ensure a child receives care? Is ESHE helping to improve this in some way?
4. Are you able to implement the ENA package of interventions? What problems do/do not exist?
5. How is your EPI program performing? What kind of ESHE technical support in this area is most helpful to you? What is your DPT3 coverage and drop out rate? What else can be done to address the remaining need?
6. Can we see an Immunization Diploma? Is this a useful tool?
7. What is your perception of community-based treatment of pneumonia?
8. Are you including HIV in the management of IMCI?
9. Are you seeing pediatric HIV cases? If yes, how are you managing them?

Managerial

10. When you are supervised, do you receive written feedback?
11. Enough capacity to do their jobs?
    a. Enough support to do job?
    b. Enough drug supplies or drug kits *esp. Coartem and Cotrimoxazole*?
    c. Is ESHE helping to improve any of these?
12. Other kinds of CHWs working in this area? Who are they and how are they managed by HEW?

13. Do you create and use an annual plan?
    a. To what extent are you able to meet your planned targets? What helps you meet you? And what more do you need, if not.
    b. **Ask to see it.**

Community Health Promoter Initiative

14. What changes do you see in the community as a result of the CHPs work?
15. Are the CHPs you supervise overburdened or will they be able to take on additional key family practices/behaviors (as per the 20 C-IMCI)?
16. Are ESHE reform activities leading to increased resources in your facility? Improved quality of care? Improved access to care, especially by the poorest?
17. How does the Community Health Promoter Initiative add value to your kebele?
18. Who helps you supervise and train CHPs? What are obstacles to supervising CHPs?
19. What other types of support would help you supervise and mentor CHPs?
20. What type of training would you like to help you supervise/mentor CHPs?
21. How do you use the data that CHPs gather?
22. How often do you hold review meetings?
23. Is the CHP handbook useful? In what way?

Community Health Promoter

1. How does the Community Health Promoter Initiative add value to your kebele?
2. How long do you plan to volunteer?
3. What motivated you to become a CHP? And remain a CHP?
4. How has your behavior changed since becoming a CHP?
5. How do you share your key messages? (i.e. coffee ceremony, church, home to home)
6. What training would help you as a CHP? What other resources would be useful?
7. How do you feel about teaching additional health messages?

Kokeb/Model Kebeles Initiative

4. What health problems have the Initiative solved?
5. Could this Initiative be replicated in other kebeles on their own?
6. What lessons have you learned about community mobilization and empowerment as a result of participating in the Initiative?

Safety Net?

2. Has ESHE made linkages with Safety Net programs? Is so, where and how?

Data Collection Instrument – REGIONAL

General

13. How has working with ESHE impacted:
    a. Capacity building (staff)
    b. Responsibilities as defined by HSDP III
    c. Specific program activities, i.e. CHPI, FHC, MCH, HS reform
14. Have you been satisfied with the quality of ESHE's work? Response? Timeliness? Working relationships?
15. Are there any gaps in assistance?
16. What emerging opportunities or priorities do you anticipate, now or in the future?
17. Would you assume responsibility for a given (any) component of ESHE? (i.e., add a line item into your budget for XXX intervention?)
18. Is it possible to replicate ESHE components in new areas on your own?

Special Pharmacies

15. What is the stock situation at facility level?
16. How drugs are being selected? (i.e. selection criteria)
17. In your opinion, are special pharmacies managed well, providing critical drugs and enhancing the health system overall?
18. How is the revenue generated in special pharmacies being used? (efficiency, mismanagement of funds, good governance)
19. Does additional revenue have an impact on drug shortages?
20. Are guidelines in place to manage revenue?
21. **Ask to see a budget (i.e. operating costs).**

User Fee Retention

17. How far along in developing User Fee: (a) Regulations, (b) Directives? What about implementing? If a long timeline, then why?
18. How informed are facilities of User Fee Proclamation?
19. Are user fee guidelines in place? If yes, has quality of services improved?
20. Are management committees operating? What is the composition? How? With what impact?
21. Does a separate account exist for fees? How is it operating?
22. Do you think that quality is sufficient to raise fees?
    a. If not, why not?
    b. What would it take?
    c. How much additional funds do you need to improve quality?
23. **On average, what is the health center budget for recurring/operating costs? (excluding salaries)**
24. **How much on average does health facility generate/year in user fees?**

Waivers/Exemptions

7. Do you think most people getting waivers deserve to be getting one?

8. When does the facility plan on revising fees?

HMIS

31. How do you ensure that quality data is collected?
    a. **Ask to see guidelines.**
    b. **Ask to see a completed official data collection form (with data collected from HMIS).**
    c. **Has your staff been trained? Are they using what they learned?**
32. What encourages health workers to collect and report quality data? Do they feel that it's important?
33. Do you give feedback to lower levels on data collection and management?
34. Is there a point person for compiling/analyzing data?
35. Is data analyzed and fed to BOFED?
36. How do you use the data collected?
37. Does it impact budgeting?

Outsourcing

3. Does outsourcing exist in your region?
4. If yes, what has been your experience with it?

Standards of Performance

5. Do standards of performance exist regarding:
    a. Service delivery protocols (IMNCI, ENA, EPI)
    b. Management standards
    c. **Ask to see the document(s).**
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Community Health Promoter Initiative

17. How many Community Health Promoters (CHPs) are in your region?

   a. Describe their activities.
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   c. Would you like a multi-purpose CHP?
18. Do you know of other similar community-based child health educators (i.e. UNICEF's community-IMCI)?
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20. Would your communities continue to sustain CHPs if ESHE were to go away?
21. Is the CHP critical for the Health Service Extension Program (HSEP) success?
22. Has the training enabled HEWs to mobilize CHPs to make change in health behaviors?

Kokeb/Model Kebeles Initiative

7. What health problems have the Initiative solved?
8. Could this Initiative be replicated in other kebeles on their own?
9. What lessons have you learned about community mobilization and empowerment as a result of participating in the Initiative?

Coordination

2. How do you coordinate the various NGOs and partners working in Child Survival (i.e. NGO Forum)? Are they working well?

Health Extension Workers

1. What is your opinion of the HSEP implementation in your region?
2. What are ESHE's contributions to HSEP rollout?

Safety Net

3. Has ESHE made linkages with Safety Net programs? Is so, where and how?

ANNEX G: PROGRESS AGAINST LOP TRAINING TARGETS

ESHE Training Summary vs. Life of Project Targets
(Nov. 2003- Sep. 2006)

Training	Amhara (Nov '03-Sep '06)	Oromia (Nov '03-Sep '06)	SNNP (Nov '03-Sep '06)	Regional Total	Target (LOP)	Achieve-ment (%)	Remarks
CHPI							
CHP	5,168	8,951	14,624	28,743	41,500	69	
ENA							
HEW	140	80	173	393	2,000	20	HEW training included in contract amendment early 2006. Training started early 2006.
HW	469	576	544	1,589	2,180	73	
EPI							
HEW	174	0	362	536	2,000	27	HEW training included in contract amendment early 2006. Training started early 2006.
HW	740	826	757	2,323	2,300	101	
IMNCI							
HEW	0	0	9	9	2,000	0	HEW training included in contract amendment early 2006. Training started early 2006.
HW	7	6	22	35	1,350	3	IMNCI planned as last intervention to be phased in. Revision and adaptation of international 11-day course took considerable time at national level.
HMIS/Supervision							
Training	241	268	241	750	480	156	
HCF							
Training	157	985	80	1,285*	2,265	57	SNNP and Amhara conducted regional TOTs and cascade trainings are ongoing. Preparation for TOT in Oromia is underway.

* Includes national-level training

Source: ESHE Training Records

ANNEX H: SUMMARY OF IMPLEMENTATION GUIDANCE

Note: A full discussion of each point that follows can be found in the relevant section of the evaluation report narrative.

Strengthening Health Worker Skills:

- In advance of IMNCI scale-up, define feasible training targets, clear objectives and a few key measures of success by project's end for facility-based IMNCI, especially for the novel approach being applied at health post level.
- Strengthen referral links between the community and health care facilities.
- In line with MOH plans, mobilize and leverage partner resources to support heavy start up costs for training and support of programs like IMNCI, and use this as an opportunity to induct new partners as part of a scale up strategy in ESHE Regions.
- Monitor and report on feasibility and effectiveness of new program components i.e. community based pneumonia treatment, newborn care.
- If feasible within the fever case management component of IMNCI, strengthen rational use of rapid diagnostic tests (RDTs) and artemesenin-based combination therapy (ACT) in the treatment of malaria at health post level.
- Catalyze and monitor implementation of 'best practices' to achieve broader ENA program scale and impact.
- Adopt successful program elements of the CTC-CNP work as a standard approach for use in emergency/post-emergency settings.
- Encourage Woreda Health Offices, Health Centers and HEWs to report the more accurate measures of EPI coverage, particularly if the true population is known.
- Define the 'unmet need' for child health services, such as unvaccinated children, and explore ways of reaching those within the worst performing ESHE Zones/Woredas.

Improved Community and Household Practices

- Focus on timely phasing-in and scaling-up of a set of high impact interventions (Lancet interventions) that will contribute to the biggest reductions in child mortality.
- In order to ensure that volunteers are trained and deployed in a sustainable fashion that supports HSEP, the evaluation team recommends that ESHE and Pathfinder harmonize approaches, messages and incentives.
- Assist the FMoH to identify and compare the community health volunteer models currently in use in Ethiopia to inform discussions of scale up.
- Continue current print activities aimed at disseminating and using the FHC and ID, ensuring that these materials are available at all points of entry into the health care system. Educating pharmacists on the FHC and ID and coaching them on how to promote the materials could further increase adoption of health behaviors.
- Assess the relative impact of radio spots in relation to their cost.

Improved Health Systems

- The evaluation team recommends that, in the area of NHA, ESHE works exclusively on fully institutionalizing the NHA.
- Capture the best-practices in 1) managing revenue from special pharmacies; 2) re-investing revenue for quality improvements; 3) good governance of revenue, including how to develop strong management boards; and 4) administrative issues with retained revenue.
- Rather than directly providing input, ESHE should train and support GOE counterparts to provide this input.
- Work with RHB's to establish an organizational entity, similar to the PPD Health Care Financing team at the central level, responsible for providing analytical input into the policy process.
- Work beyond the TOT activity to ensure implementation of the legal framework by also providing 'end-user' training support in non-ESHE woredas.
- Conduct limited analytical work to explicitly link work in health systems to improvements in child health.
- Translate the Integrated Supervisory Checklist and Performance Standards into Amharic, and other languages where appropriate.
- Assist regions in developing plans for institutionalizing and sustaining the supportive supervision model.
- As part of a broader performance improvement mandate, ESHE should continue to strengthen but also institutionalize the capacity of health staff to do self-assessments and monitor their own quality and performance, especially between quarterly supervisory visits.
- Place increased emphasis on the application of the management standards.
- Explore the feasibility of integrating developed service delivery and management standards into pre-service training for all types of health care providers.
- Consider adding (or bolstering where already added) a technical training element to the agenda for review meetings.

Linkages with Other USAID Programs

- Forge a closer partnership between ESHE and Safety Net program managers and front-line staff.